Request for Release of Dental Records

Dr. Teddi Olszewski, DMD
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413-584-2902 * Fax 413-586-9904

I, _____, hereby grant permission to
(Print patient name) (Date of birth)

_____
(Previous dentist's name)

_____
(Previous dentist's address & telephone number)

to release my dental health records -

**** *Diagnostic* Copy of Dental X-rays ****
Treatment Notes
and
Periodontal Charting

- directly to (*email/digital format preferred*):

Dr. Teddi Olszewski, DMD
Northampton Family & Cosmetic Dentistry
264 Elm Street
Northampton, MA 01060
admin@enjoyyoursmile.com

Signature: _____ **Date:** _____
(*If patient is a minor, parent or guardian must sign*)

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