Daren Dental
FAMILY DENTISTRY

Debra K. Daren DDS

Release of Records Authorization

Today's Date: _____

To Dr:_____

Address_____

City_____ State _____ Zip Code_____

I, _____ hereby authorize and request the release of my dental records with radiographs & dates, diagnosis, concerns and/or treatments for myself and/or family members be sent to:

Debra K Daren
131 Boston Post Road
P.O. Box 632
East Lyme, CT 06333
Email: info@darendental.com (Dentrix Compatible)
Fax: 860.739.3067

_____ _____

Print Name *Signature*

If you have any questions, my telephone contact is: _____

Also release records for: _____

_____