GARGANO
FAMILY DENTISTRY

Personalized Care From Our Family to Yours

Authorization for the Release of Dental Records

Date:_____

I am requesting dental/medical records and/or x-rays to be released to:

Gargano Family Dentistry

21 Washington Ave. Unit A

North Haven, CT 06473

(P) 203-239-2356; (Fax) 203-239-3985

Please send digital xrays (Dexis format preferred) **to:**

smiles@garganofamilydentistry.com

_____(signature)

_____(print name)

As parent/legal guardian, I am requesting dental/medical records and xrays for the following family members:

Print name:_____

Print name:_____

Print name:_____

Print name:_____