Robert J. Perreault, DDS, PC
12 Main Street
Atkinson, NH 03811
(603) 362-8410

Dental Records Release Form

I, (print patient or guardian name) _____,
DOB: _____, hereby authorize the doctor and staff of

_____

to release records or knowledge concerning my dental health to:

Name of Dental Practice: Atkinson Dental Health Center
Address: 12 Main Street, Atkinson, NH 03811
Telephone Number: 603-362-8410

Email: info@atkinsondentalhealthcenter.com
(Documents and x-rays that are emailed are of much better quality than copied documents.)

I am requesting that you release the following (check 1 or both):

1. _____ x-rays 2. _____ treatment record/recommendations

DATE OF LAST FMX or PAN: _____

Patient Signature**:** _____

Other family member: _____DOB: _____

Other family member:_____ DOB: _____

Other family member: _____ DOB: _____