REQUEST FOR RELEASE OF RECORDS

Send this form to the dentist listed below.

Date: _____

REQUESTED FROM:

DOCTOR'S NAME: _____

ADDRESS: _____

CITY/STATE: _____

I hereby authorize the release of my (or dependent's) dental records and xrays.

Please forward to:

Dr. Douglas S. M. Callis, D.M.D.
515 Old Toll Rd.
Madison, CT 06443
(203) 421-4100
Fax: 203-421-4159 Email: callisdmd@yahoo.com

Patient/Family Name: _____

Address: _____

City/State: _____

Patients/Parent Signature: _____