RECORDS RELEASE AUTHORIZATION

To_____
DOCTOR OR HOSPITAL

_____
ADDRESS

FAX # _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY DENTAL RECORDS AND X-RAYS TO:

Dr. Douglas M. Hope, D.M.D.
8 Plank Hill Rd.
Simsbury, CT 06070
(860) 651-4915
FAX (860)658-1996
email: drhopect@gmail.com

NAME_____DATE_____

ADDRESS_____

SIGNATURE_____
(IF RELATIVE, STATE RELATIONSHIP)