WALTHAM FAMILY DENTAL - RECORD RELEASE FORM

30 GRANT ST, WALTHAM, MA 02453

T: 781 894 1634 EMAIL: office@walthamfamilydental.com

I, _____(name) hereby authorize the release of my following records:

Check all that applies:

- Xrays
- Charts
- Notes

Please send my records via. Email / Mail / Fax **(Check One)** to the address given below:

Email:_____

Address:_____

Fax:_____

By selecting Email, you take full responsibility that the private dental records are going to be sent over the internet without security.

_____
Name Of Patient

_____
Signature

_____
Date

We require 5 working days from the time we receive this document to process your request.