Area Dental Services, LLC
603-372-2768

Records Release Request

Date:_____

Patient Name:_____ DOB:_____

- Chart Notes
- Perio Chart
- X-Rays

I authorize the release of my dental records and medical records relevant to dental treatments or copies of such and request that they are transferred to:

Area Dental Services
11 Dunning St; #1
Claremont, NH 03743
603-372-2768

Email: areadentalservices@gmail.com

Patient, Parent or Guardian Signature: _____