Area Dental Services, LLC
Jack H. Weaver, DDS
11 Dunning Street, Suite 1
Claremont, NH 03743
603-372-7268

RECORDS RELEASE REQUEST

Date:_____

Patient Name:_____ DOB:_____

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 Street, Suite 1 Claremont, NH 03743 603-372-7268	❑ Chart Notes ❑ Perio Chart ❑ X-Rays
Email: areadentalservices@gmail.com We prefer the releasing doctor to send the records by email.	

Release Records From:

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Patient, Parent or Guardian Signature: _____