Authorization for Release of Dental Records and X-Rays

I, (print patient or guardian name)_____,
hereby authorize the doctors and/or staff of Easterseals New Hampshire, to release records and x-rays concerning dental health for the following:

Patient name: _____Birth date:_____

Patient name: _____Birth date:_____

Patient name: _____Birth date:_____

Patient name: _____Birth date:_____

Please release records to:

Name:_____

Street Address:_____

City, State, Zip Code:_____

Practice Telephone Number:_____

Signed (patient or guardian name)_____

Date:_____

Mail form to Easterseals New Hampshire, 555 Auburn Street, Manchester, NH,
Email to ESdental@eastersealsnh.org , OR
drop off in front lobby between 8:30 am-4:30 pm M-F