RECORDS RELEASE AUTHORIZATION

TO:	
PREVIOUS DENTAL CARE PROVIDER	
ADDR	ESS
ADDR	ESS
I HEREBY AUTHORIZE AND REQU	IEST VOLUTO RELEASE TO:
THEREDI MOTHORIZE MAD REQU	EST TOO TO RELEASE TO.
Alicia C. Almeida, D.M.D.	
305 CHURCH ST	
NAUGATUCK, CT 06770	
TELEPHONE ((203) 729-5741
Email: smiles@dralmeida.net	
THE COMPLETE HISTORY RECORDS IN YOUR POSESSION,	
CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE	
CONCERNING WIT IEERLESS MIND/C	JK TREATMENT DORING THE
DEDICE EDOM	TO.
PERIOD FROM	10
NAME	
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ADDRESS	
SIGNATURE	
DATE	
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