RECORDS RELEASE AUTHORIZATION

TO: _____

PREVIOUS DENTAL CARE PROVIDER

_____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU 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

PERIOD FROM _____TO_____

NAME _____

ADDRESS _____

_____

SIGNATURE _____

DATE _____