RECORDS RELEASE/REQUEST

To _____
(Doctor)

Address _____

City _____ State _____ Zip _____

I hereby authorize the release of my _____

_____ or copies of such and request they be

Transferred to:

info@robsondental.com

JAMES E. ROBSON, D.D.S.
279 BOSTON POST ROAD, P.O. BOX 309
EAST LYME, CT 06333
TELEPHONE (860) 739-3881
FAX (860)739-6754

_____
Print Name of Patient

From: _____ To: _____
Date of Records

_____
Patients Signature Date