MEDICAL RECORDS RELEASE AUTHORIZATION

Please sign and mail out to your prior dental office before your scheduled appointment with us.

TO: ____

Name of former dental practice

I hereby authorize the release of all my medical and dental records including records and x-rays pertaining to my treatment, progress and diagnosis.

I further authorize you to provide to and discuss any information with respect to my medical and dental condition or treatment either formally or informally

Release records to:

Rebecca Cochrane, DMD, Ph.D.

264 Elm St., Suite 11

Northampton, MA 01060-2857

Phone: (413) 584-1301

Fax: (413) 341-5293

E-mail: FrontDesk@cochranedental.com

Patients name:______________________________Date of birth:________________

Current street address:____

City: ___________________________ State: __________ Zip: ________________

Phone:__________________________ e-mail: _____________________________

Signature: ____

Authorized representative's signature: ______________________________________

Relationship to patient:____

Today's date: _____________________

Processed on (date):________________