



AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

TO: _____ (your former dentist name and address)

I (print patient or guardian's name) _____, hereby authorize the
doctor and staff of (your former dentist) _____ dental office to
release records or knowledge concerning the dental health of
[patient(s) name] _____ to:

Eugene B. Nichols, DMD
15R Mechanic Street
Foxboro, MA 02035
FAX 508-543-2201

I specifically request that you release copies of:

All x-rays All treatment notes Full mouth Perio Charting

Signed (patient or guardian name) _____

Print name (patient or guardian name) _____

Date: _____