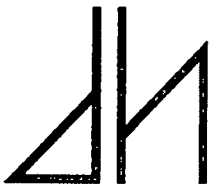

day hill dental

Dr. David Bloom, DDS *Dr. Gregory Farber, DMD* *Dr. Jeffrey Chu, DMD*

Dr. Hannah Hughes, DMD *Dr. Steven Meltzer, DMD*

RECORDS RELEASE/REQUEST

To_____
(Doctor/Hospital)

Address_____

City_____State_____Zip_____

I hereby authorize the release of my X-rays/records or copies of such and request that they be transferred to:

Day Hill Dental
1060 Day Hill Road
Windsor, Connecticut 06095
P (860) 688-5595
F (860) 688-7403

ALL X-RAYS CAN BE EMAILED TO:

frontoffice@dayhilldental.com

_____
Print Name of Patient

Date of Records From: To:

Patient's Signature: Date: