EUGENE B. NICHOLS, D.M.D.
508.543.2233
Family Dentistry

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

To: _____ (former dentist)

_____

_____

(___)____ - _____ (phone number)

I (patient name/guardian name) _____, hereby authorize the doctor and staff of _____dental office to release records or knowledge concerning the dental health and history of _____ (patient's name) to:

Eugene B. Nichols, DMD
15R Mechanic Street
Foxboro MA 02035

dr@nicholsfamilydentistry.com

**I specifically request that you release copies of all x-rays, treatment notes, and perio charting.**

Signed _____ (patient/guardian)

Print Name _____

Date: _____