# Northeast Dental Group

**479 Buckland Rd., South Windsor, CT 06074**
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**northeastdentalgroup.com**

*Authorization for Release of Dental Records and X-rays*

**I, (print patient or guardian name) _____, hereby authorize the doctors and staff of Northeast Dental Group to release records or knowledge concerning my dental health to:**

**Full Name _____**

**Street Address _____**

**City, Zip Code _____**

**Practice telephone number: _____**

**Signed (patient or guardian name)**

**_____**

**Printed name (patient or guardian name)**

**_____**