RECORDS RELEASE FORM

Date _____

To _____
(Previous Office/Doctor name)

Address _____

City _____ State _____ Zip_____

Phone # _____ Fax# _____

I authorize the release of my dental records and medical records relevant to dental treatment, or copies of such, and request that they are transferred to:

Pleasant Dental Center
George A. Ezzi, D.M.D.
126A Pleasant Valley St., Suite 4
Methuen, MA 01844
Telephone: (978) 688-9200 Fax: (978) 688-4949
Email: pleasantdentalcenter@comcast.net

Please list any other family members:

Name	Relationship
1._____	_____
2. _____	_____
3. _____	_____
4. _____	_____

_____ _____

Print name of Patient and SS# Signature (patient, parent or guardian)