



I _____:
(Please Print)

Authorize the release of my dental records, including copies of radiographs, treatment records and medical history for patient:

_____.

To be sent to:

Failla and DeFrancesco Family Dentistry
976 Main Street
Waltham, MA 02451

If you are able to provide digital x-rays please e-mail to:

fddental@yahoo.com

Patient signature or Legal Guardian signature

Date