Duxbury Dental Associates

**Release of Records from Duxbury Dental Associates**

Date of Request: ____________________________

I hereby authorize Duxbury Dental Associates to release my records to:

_________________________________ at _________________________________________________

Office Name Mailing Address

_______________________________________ __________________________________

Telephone Number Email Address

Patient: __________________________________________ DOB: _________________

Patient: __________________________________________ DOB: _________________

Patient: __________________________________________ DOB: _________________

Patient: __________________________________________ DOB: _________________

Purpose: ________________________________________________________________________

Signature: ___________________________