Duxbury Dental Associates

Release of Records to Duxbury Dental Associates

Date of Request: _____

I hereby authorize:

_____ to release my records to Duxbury Dental Associates.

If you need to mail information, please send to PO Box 2776, Duxbury, MA 02331.

If you are emailing information, please email to frontdesk@duxburydental.com.

If you have any questions, please call their office at 781-934-2941.

Please send all information prior to _____
Date of Appointment

Please send records for the following: (Please print)

Patient: _____ DOB: _____

Patient: _____ DOB: _____

Patient: _____ DOB: _____

Patient: _____ DOB: _____

Signature: _____ Date: _____