THREE RIVERS DENTAL PLLC

Record Release Form

I _____ hereby authorize:

(Patient Name & DOB)

Dr. _____

(Previous Doctor)

Practice Name: _____

(Previous Office Name and Location)

To release my entire record and insurance information including any xrays, treatment plans, and records of any treatment or examination rendered to me.

Patient Signature _____ Date_____

Please email digital xrays to info@threeriversdentalnh.com

Three Rivers Dental - 655 Portsmouth Ave. Greenland, NH 03840

Phone: (603)-373-0500 Fax: (603)-373-0502

Thank you!