Records Request

I, _____, give _____
(Doctor/Hospital)
Permission to release/transfer copies (including radiographs and photographs, if applicable) of my child/children's dental records to:

Dr. Deborah A. Himelhoch
550 Worcester Rd
Framingham, MA 01702
or
drhimelhoch@verizon.net

_____
Print Name of Patient or Patients

From:_____To:_____
Date of Records Date of Records

_____
Patient's (or Parent's) Signature Date