Luciano D. Marini, D.M.D.

26 Lakeside Blvd East ♦ Waterbury ♦ CT ♦ 203-575-9097 ♦ Fax 203-575-0824 ♦ drmarini@waterburysmiles.com

REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and x-rays and we hereby, request that you release the following patient's records:

Patient's Name : _____

DOB : _____

Address :

Name of Previous Dentist: _____

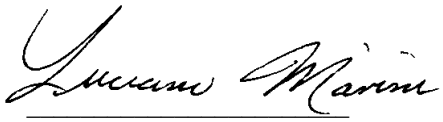
Address: _____

Signature _____

_____ _____

Guardian (if applicable) Date

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.



_____ _____

Luciano D. Marini, D.M.D. Date

We thank you in advance for help and cooperation in this matter.

Please e-mail records to drmarini@waterburysmiles.com