860-627-5232
office@dasilvadental.com
148 North Road
East Windsor, CT 06088

Dental Records Release Authorization

I, ____, authorize the release of copies of my recent radiographs and/or treatment records to be sent electronically to DaSilva Dental LLC who I have chosen as my new dentist.
Please send my dental records electronically to: office@dasilvadental.com

This patient has an appointment with DaSilva Dental on: ______________________________

Previous dentist name: ____

Office phone: _______________________________ Office fax: ______________________________

I release Dr. Brian DaSilva from any laws related to the disclosure of confidential or privileged information for the purposes of the release of these records.

____ _________________________

Patient Name Date of Birth

____ _________________________

Patient Signature Date