FAMILY DENTISTRY
OF CENTRAL CONNECTICUT

Request for Transfer of Records

I, _____, hereby request and give my permission to Dr. _____ to provide Family Dentistry of Central Connecticut any and all information regarding past dental care for the following individuals: _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

Family Dentistry of Central Connecticut

6 Park Place Unit 2 New Britain CT 06052

phone 860-438-6687

fax 860-357-2139

info@DrMaule.com

Thank you,

Printed Name _____

Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____
(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address: _____

Phone: _____