

Permission to Release Records to:
☞ Hergott Dental Associates ☞

To Dr. _____

I hereby authorize the release of dental records (including radiographs) or copies of such and request that these are transferred to:

Dr. David K. Hergott DMD
Dr. Sara E. Curcio DMD
www.hergottdental.com
166 South Broad Street
Meriden, CT 06450
(203) 235-3738 fax (203) 235-3808
erika@hergottdental.com

Patient's Name: _____ Date of Birth: _____
(Print)

Patient's Address: _____

Signature: _____ Date: _____
Patient, Parent or Guardian

Please write below the dates when the patient's last prophylaxis, bitewing x-rays, and Pan/FMX were completed.

If possible, please email us any digital radiographs to:
drdave@hergottdental.com (Dexis or JPEG format).

Prophy: _____ Exam: _____

FMX: _____ Bitewings: _____