# 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. Tracy C. Kania DDS
www.hergottdental.com
166 South Broad Street
Meriden, CT 06450
(203) 235-3738 fax (203) 235-3808
admin@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 prophy, bitewing x-rays, and Pan/FMX were completed.
If possible, please email us any digital radiographs to: admin@hergottdental.com (Dexis or JPEG format).

Prophy: _____ Exam: _____

FMX: _____ Bitewings: _____