REQUEST FOR RELEASE
OF
MEDICAL RECORDS

TO:

_____
Doctor's name (Print)

_____
Address

_____ _____
City State Zip

I hereby request that my dental records be released to :

dickinsonbranon@dbdentalcarevt.com
or mail to:
Dickinson & Branon Dental Care
12 Mapleville Depot
St. Albans, Vermont 05478

_____
Patient Name (print)

_____
Patient Signature