Authorization for Records Release from South Shore Dentistry

Patient Name: ________________________________

Patient's DOB: _______________________________

I, the above named patient, hereby authorize and request that you release the complete dental records and radiographs in your possession that relate to my past and current treatment with Dr. Larry D. Burt, to my new dentist who is located at the following address:

Practice Name: ____________________________________

Address: ____

City, State, Zip: ___________________________________

Phone: ____

Fax: ____

Email: ____

Thank you,

____ ___________________

Patient Signature Date

Please return this form by fax to South Shore Dentistry at 781-335-5878.