South Shore DENTISTRY
Comprehensive. Compassionate. Convenient.

Authorization for Records Release from Previous Dentist

To: _____

_____

_____

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 to Dr. Larry D. Burt, who is located at the following address:

South Shore Dentistry
851 Main Street, Suite 8
South Weymouth, MA 02190
Phone: 781-331-3030
Fax: 781-335-5878
Email: _____

Thank you,

_____ _____

Patient Signature Date