Permission for Records Release

I authorize _____to release my records to

North Hampton Dental Group

2 Juniper Road

North Hampton, NH 03862

Phone (603)964-6300 Fax (603) 964-1194

E-mail: office@northhamptondentalgroup.com

Patient Signature_____ Date_____

Please Print Name _____

Doctor Signature_____Date_____

Reason why requested_____

_____