Eric Maser, D.M.D.
30 Orchard Street ~ *Dover, NJ 07801* ~ *973-366-0311*

Request for Release of Dental Records

To: _____
(doctor/ hospital)

_____

_____

I hereby authorize the release of the following:

- ❑ Complete dental record
- ❑ Dental x-rays
- ❑ Dental record from _____ to _____

Please send to:

frontdesk@maserdental.com

Patient Name: _____ DOB: _____

Current address: _____

_____

Home Phone #: _____

Former address: _____
(if applicable)

_____

Patient Signature: _____ ***Date:*** _____