Record Release Form

Patient Name: ____

Date of Birth: ________________________

I authorize the release of my personal information and dental x-rays to:

Traci Portnoff, DMD
65 West Main Street
Westborough, MA 01581
(508) 366-3623

Please email digital x-rays (jpeg file) to: **donna@portnoffdental.com**

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Patient Signature **Date**