Christina N. Shaw, DMD
11 Mayo Drive, Holden, MA 01520
(508) 829-4909

Release of Records

Patient Name:____

Date of Birth:_______________________

Release Records to (select one):

☐ **Shaw Family Smiles, 11 Mayo Drive, Holden MA 01520**

info@shawfamilysmiles.com

OR

☐ Patient / Practice Name: ________________________________

Phone Number:____

E-mail:____

Mailing Address: _____________________________________

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I hereby authorize the doctor and staff to release records concerning my dental health. I understand information disclosed may include reports of examinations, treatment provided, x-rays, and other records that pertain to my dental information.

Additional Notes: ____

Signature: ____ Date: ___________________