Jeffrey M. Pivor, D.D.S.

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Name of Patient_____ DOB_____

Address of Patient_____

I hereby authorize_____
(Name of Dentist, Doctor, or Hospital)

to release my dental records, including history, treatment/progress notes, and current x-rays, to the dental office of:

Jeffrey M. Pivor, D.D.S.
495 Connecticut Avenue
Norwalk, CT 06854
203-838-3321
Fax (203) 838-3314
jpivordds@yahoo.com

Signature of Patient_____Date_____
(Parent or Guardian if patient is a minor)