DAVID R STEBBINS DMD

Authorization for Release of Medical Record

Name of Patient_____ DOB_____

Address of Patient_____

I hereby authorize _____
(Name of Doctor or Hospital)

to release originals or duplicates of my medical information, including history, treatment/progress notes, and current x-rays, to the office of:

David R. Stebbins, D.M.D. LLC
148 East Avenue, Suite 3J
Norwalk, CT 06851
203-866-0415
Fax 203-354-9561
frontdesk@davidstebbinsdmd.com

Dates of Records:_____
(from MM/DD/YY) (to MM/DD/YY)

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

FOR OFFICE USE ONLY

Date request received_____

Date records and x-rays sent _____