

Authorization to Release Information to  
Dr. Jeffrey A. Burns  
933 Hartford Turnpike  
Vernon, CT. 06066  
860-870-4410  
860-870-2567Fax  
[frontdesk@drjeffreymburns.com](mailto:frontdesk@drjeffreymburns.com)

I Hereby Authorize:

\_\_\_\_\_  
\_\_\_\_\_

To release a copy of my dental record and/or x-rays to Dr. Jeffrey A. Burns.

The copies are to be:

Mailed \_\_\_\_\_

E-mailed \_\_\_\_\_ (jpegs Please)

Faxed \_\_\_\_\_

Picked up by \_\_\_\_\_

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Patient/Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

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If you have received this fax in error, please contact us at:

Office Name: Jeffrey A. Burns, D.M.D.  
HIPAA Privacy Officer: Dr. Jeffrey Burns  
Phone Number: 860-870-4410  
Email Address: [frontdesk@drjeffreymburns.com](mailto:frontdesk@drjeffreymburns.com)