Authorization to Release Information to

Dr. Jeffrey A. Burns
933 Hartford Turnpike
Vernon, CT. 06066
860-870-4410
860-870-2567Fax
frontdesk@drjeffreyburns.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 _____