Madison Dental Spa

Moumen Almouzayn D.M.D.
90 Wall Street, Suite 100
Madison, CT 06443
203-245-5101

Release of Dental Records

Date: _____

To whom this may concern,

I, _____ hereby give my consent and authorize
(**Patients Name**)

_____
(**Former Dentist's - Name, Address, City, State, Zip Code and Phone #**)

to provide my dental records and most current set of dental radiographs to the office of Dr. Almouzayn, Madison Dental Spa upon receipt of this letter.

If the X-Rays are on a digital system, please email to info@madisondentalspa.net.

Thank you.

Sincerely,

_____
Patient's Name (Printed)

_____
Patient or Guardian Signature