Records Release Request

I,_____authorize the release of my dental x-rays and records or copies of such and request they be transferred by mail or e-mail to:

Meadow Place Dental
200 North Main Street Suite 1102
East Longmeadow, MA 01028

E-mail address: xrays@meadowplacedental.com

_____ _____
Signature of patient Date of birth

_____
Today's date