BRISTOL
Family DENTAL

Authorization to Forward Dental Records

To: Dr. _____

Address: _____

_____

Please submit copies of my dental records and x-rays to:

To: **Bristol Family Dental**
815 Pine St.
Bristol, CT 06010
860-589-2794

E-mail address: office@bristolfamilydentalct.com

Thank you for your prompt attention to my request.

_____ _____
Patient Name Date of Birth

_____ _____ / _____ / 2022
Patient Signature Today's Date