Paul J Leckowicz, DMD
103 Market Square
Newington, CT 06111

Authorization for Release of Dental Records

Patients Name: _____

Address: _____

Previous Dentist:: _____

I hereby request and authorize the release of all information, without limitations regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes medical-dental history, x-ray findings, diagnosis, prognosis, and access to all hospital records and photocopies of the same.

I request that you release the above information to:

Paul J. Leckowicz, D.M.D.
103 Market Square
Newington, CT 06111
(860)-666-4678- phone
(860)-666-7832- Fax
Pleckowicz@dentistinnewington.com –email
*please send as DEXIS Digital X-ray Image File if possible

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Patients (or Legal Guardians) Signature Date