Dear Dr. ___________________

We would like to request all records and x-rays for

______________________________ to be sent to our office.

Authorization to release medical information

I authorize to release of all my medical files and x-ray from

Dr. _____________________ to Evergreen Family Dental

1300 Post Road, Suite 101, Fairfield, CT 06824

Signature:______________________________

Date: _____________

Thank You,

Min-Sung Yoon, DDS
Patrice Foudy, DDS