Joseph E. Kuzmic, DDS
Christopher M. West, DDS

MYSTIC DENTAL GROUP

A PROFESSIONAL CORPORATION

117 Cow Hill Road
Mystic, CT 06355
860.536.4951

Date: _____ /_____ /_____

I, _____, do hereby authorize the release of all dental records

including x-rays from the office of _____ to be sent

to _____, at _____
(Office name) *(Street # & Name)*

in _____.
(Town & State)

I also release the above named offices from all legal responsibility that may arise from this authorization.

If sending information ***to*** Mystic Dental Group, please send to:

email: **mdg-mdg@snet.net**

fax: **860-572-1409**

Patient Name: _____

Address: _____

_____

Signature: _____
(Patient or person authorized to sign for patient)