Brickwalk
DENTAL
FAMILY & COSMETIC DENTISTRY

Patient Records Release

Dear Dr. _____,

We would like to request all clinical notes and x-rays for _____
to be sent to our office. (patient name)

Authorization to release Medical Information

I authorize the release of all my medical files and x-rays from Dr. _____ to Brickwalk Dental

via e-mail:
xrays@brickwalkdental.com

or via mail:
Brickwalk Dental
1305 Post Road Ste 200
Fairfield, CT 06824

_____ _____
Patient Signature (Custodian Signature if Minor) Date