LINDA ROBINSON DENTAL
380 RUSSELL STREET SUITE 101
HADLEY, MA 01035
413-587-0888/fax 413-587-0808
DrRobinson@LindaRobinsonDental.com www.LindaRobinsonDental.com

Authorization for Release of Dental Records:

I, (print name of patient) _____, hereby authorize the doctors of

(print name of dental office) _____ to release my dental records,

Including x-rays **AND** chart notes as well as knowledge concerning my dental health to:

Linda Robinson Dental
380 Russell Street, Ste. 101
Hadley, MA 01035
** drrobinson@lindarobinsondental.com

Signed (patient or guardian name) _____

Printed name (patient or guardian name) _____

Please complete this form and return to Linda Robinson Dental at your earliest convenience.