



RECORD RELEASE

I, _____ DOB _____ hereby grant authorization to

Please clearly print previous dental office name, address and phone #

to release my dental records including radiographs to:

Dr. Gregg Hillery
20 ½ South State St.
Concord, NH 03301
P-(603) 224-2555
F-(603) 226-3029
hillerycastle@comcast.net

Please include the following family members:

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

Thank you,

Patient Signature

Date