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## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's name and address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please forward any x-rays and other dental records as necessary for the patient above to the office of Dr. Steven S. Shaw. You may email x-rays to the following email address: [info@backcovedental.com](mailto:info@backcovedental.com)

If you have any other questions, please feel free to contact our office at (207) 773-3794. Thank you.

Patient's signature: \_\_\_\_\_  
(Parent or Guardian)

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