William J. Lewis, D.D.S.
Family Dentistry

3 Courthouse Lane, Unit 7
Chelmsford, MA 01824
(978) 256-3909
Fax (978) 441-3131

RECORD RELEASE REQUEST

Date:_____

My permission is granted to Doctor_____

To release my x-rays/records to _____

_____

_____

Patient(s) name and date of birth: _____

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_____

Address: _____

_____

Signature of patient and/or guardian:_____