Litchfield Dental Associates, LLC

Steven Sideris, D.D.S.
David Ritter, D.D.S.
Bradford Pinkos, D.M.D
63 West Street, Litchfield, CT 06759
860-567-9488
litchfielddental@sbcglobal.net
www.stevensiderisdds.com

AUTHORIZATION TO REQUEST CONFIDENTIAL PATIENT INFORMATION

I hereby authorize release and request a copy of my full dental records including, but not limited to : personal patient information, medical and dental history, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and any other related materials.

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date of Birth : _____

Email: _____

Please send my records to:

Litchfield Dental Associates
P.O. Box 414
Litchfield, CT 06759
860-567-9488

litchfielddental@sbcglobal.net

(Dexis format if available or jpeg please)

Signed: _____ Date: _____
Patient, Guardian, or Authorized representative

Office use only:

Initials: _____ Date: _____