FANTARELLA
DENTAL GROUP
TOMORROW'S TECHNOLOGY TODAY

Dear Dr. _____

Address:_____ Phone: _____

City:_____ State:_____ Zip: _____

I am requesting dental/medical records and /or x-rays to be released to:

Fantarella Dental Group
127 Washington Avenue
West Building 2nd Floor
North Haven, CT 06473

Please forward requested information to the above listed Doctor in a timely manner.
Thank you in advance for your cooperation.

_____
SIGNATURE

_____ Patient DOB_____
PRINT NAME

_____
DATE

If applicable, as parent /guardian I am additionally requesting dental/medical records and x-rays for the following family members:

_____ Patient DOB_____
PRINT NAME

_____ Patient DOB_____
PRINT NAME

_____ Patient DOB_____
PRINT NAME

_____ Patient DOB_____
PRINT NAME

Please send digital x-rays to: (DEXIS FORMAT BEST)
office@fantarelladental.com