Record Release Form

Patient Name: _____

Date of Birth: _____

I authorize the release of my personal information and dental x-rays to:

Cornerstone Dental Care
1300 Union Street Suite G-101
Westborough, MA 01581
(508)366-3623

Please email digital x-rays, in JPEG (jpg.) format to:
info@cornerstonedentalma.com

_____ _____

Patient Signature **Date**