lorna lally, dmd
FAMILY DENTISTRY

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Name of Patient: ____

Date of Birth of Patient: ____________________

Address of Patient: ____

City:____________________________ State: _________ Zip Code: _________

Phone Number: ____________________________

Additional Family Members to be Included (Minors Only), if applicable:
Name: _________________________________ Date of Birth: ___________________
Name: _________________________________ Date of Birth: ___________________
Name: _________________________________ Date of Birth: ___________________

I, __________________________, hereby authorize Lorna Lally DMD to release the dental records of those patients listed above to:

Name of Office: ________________________________

Email Address of Office: ____________________________________

Other Office Contact Information: ______________________________________

I will not hold Lorna Lally DMD responsible for any misuse of this information that may occur after the transfer of information.

Signature of Patient or Guardian: ____

Printed Name of Patient or Guardian: ____

Date: ____________________________

Lorna Lally DMD
109 College Avenue
Somerville, MA 02144 | Office: (617) 666-1613
frontdesk@lornalallydmd.com