

**PRINCETON DENTAL GROUP
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PRINCETON, NEW JERSEY 08540
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FAX 609-924-7166**

DENTAL RECORDS RELEASE

PATIENT REQUESTING RELEASE:

Name: _____

Address: _____

Telephone: _____

Date of Birth: _____

I, _____, request the release of my dental records.
Please forward copies to:

Signature of Patient (parent or guardian if minor)

Date