The Dental Center LLC.

XRAY AND RECORDS RELEASE FORM

PLEASE COMPLETE AND SEND OUT TO YOUR PREVIOUS DENTIST AS SOON AS POSSIBLE.

Date:
Name:
Address:
Date of Birth:

I hereby request and authorize **Dr.** _____ to transfer my Dental Records and X-Rays to:

The Dental Center, LLC
Barbara Honor, D.M.D.
Brian Bell, D.M.D.

Please circle the Dental Office address where you want your x-rays sent:

2304 Berlin Turnpike Newington, Ct 06111
860-666-1000
860-666-0090 fax
dpbelldmd@gmail.com

42 Wintonbury Mall Bloomfield, Ct 06002
860-242-1230
860-242-8477 fax
bhonordmd@gmail.com