Camillo L. Fontana, DMD, LLC
Family Dentistry

Dental Records Release

Patient:_____

D.O.B._____

I, _____ authorize the release of my dental records and x-rays to the following:

Camillo L. Fontana DMD, LLC
1817 Black Rock Tpke
Fairfield, CT 06825
203-333-4700
FontanaFamilyDentalCare@gmail.com

Please send x-rays Dexis or JPEG format

_____ Date:_____

Patient's signature