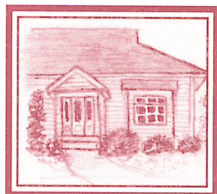

Gregory P. Gutgsell, D.D.S.
Darren M. Phipps, D.D.S.
Professional Association

Please fill out this form and then send it to your former dentist

Authorization for Release of Dental Records

Name of patient: ____

Patient's DOB: ____

Address: ____

City: __________________________ State: ______ Zip: _______________

Additional family members to be included:

Name: _________________________________ DOB: _______________

Name: _________________________________ DOB: _______________

Name: _________________________________ DOB: _______________

I, (print patient or guardian name) ____________________________, hereby authorize the release of dental records to:

Digital records (PREFERRED):

laura.gutgsellandphipps@comcast.net

Paper or film copies:

Darren Phipps, DDS
P.O. Box 265
New London, NH 03257
(603) 526-6655

Signed (patient or guardian signature): ____________________________________

Date: ________________