



**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):

[heidi.o.gutgsellandphipps@comcast.net](mailto:heidi.o.gutgsellandphipps@comcast.net)

Paper or film copies:

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

Signed (patient or guardian signature): \_\_\_\_\_

Date: \_\_\_\_\_