Thomas P.A. Carchidi, D.M.D.
FAMILY DENTISTRY

167 Village Street
Medway, Massachusetts 02053
Telephone: (508) 533-6400
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RECORD RELEASE AUTHORIZATION

Our patient is requesting the release of their records with your office:

I _____ hereby authorize you _____
(Please print Patient Name) (Dentist name/office)
to release any necessary x-rays and records to my new dentist Dr. Thomas P A Carchidi, 167 Village Street, Medway, MA 02053. Please mail or fax (508-533-6400) any pertinent information.

Patient Signature: _____ Date:_____

Please include dates of the patient's last full set of x-rays, bitewing x-rays and dental Prophylaxis/Maintenance procedures.

Thank you,

Diane LeVasseur
Office Manager