

BEACHCREST DENTAL, INC.  
Bruce C. MacKinnon, D.D.S.  
Brett L. Bruno, D.D.S.

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS  
FROM THE OFFICE OF:

\_\_\_\_\_

Dentist

\_\_\_\_\_

Address

\_\_\_\_\_

Telephone

TO BEACHCREST DENTAL, INC.

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DOCTOR: You are hereby requested to release all dental records, including radiographs and treatment notes, to Beachcrest Dental, Inc.: Bruce C. MacKinnon, D.D.S., Brett L. Bruno, D.D.S.. You are released from any liability that may arise from this authorization. I hereby authorize the release of my/my child's dental records.

\_\_\_\_\_

Name of Patient

\_\_\_\_\_

Address

\_\_\_\_\_

Signature

\_\_\_\_\_

Relationship

\_\_\_\_\_

Date

\_\_\_\_\_

*Date Appointment Scheduled*

Feel free to email records to : ***info@beachcrestdental.com***

**88 Beach Street \* Westerly, RI 02891 \* 401-596-0075 \* Fax 401-596-0388**

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