Family Dentistry
Beachcrest Dental

Brett L. Bruno, D.D.S.
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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

_____
Name of patient

_____
Date of Birth

_____
Address

I, _____, hereby request and authorize _____
Patient or Guardian Name (please print) Practice or Dentist Name

to disclose and provide copies of any and all clinical treatment records and information concerning my care to:

Beachcrest Dental
88 Beach Street
Westerly, RI 02891
401-596-0075
401-596-0388 (fax)

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

Signed:_____ Date:_____
Patient or Guardian

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