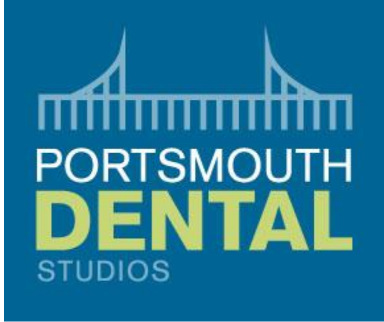

PORTSMOUTH DENTAL STUDIOS
DRS. HUNTER AND LAMOTHE
231 CORPORATE DRIVE, SUITE 101
PORTSMOUTH, NH 03801
603-431-7605

Date: ____________________

I hereby authorize:

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to release my records to: **Portsmouth Dental Studios at the address listed above OR they may be faxed to: 603-433-5381.**

Please Email X-rays to: healthysmiles@portsmouthdentalstudios.com

Patient Name:____________________________________ DOB__________________

Address____

Address____

Signature____Date______________