
# Request to Release Records

Date _____

Patient Name(s):_____
_____

I give my permission to _____to release my records and/or x-rays to:

Dr. Kate Glazer

Shoreline Children's Dentistry

934 Boston Post Rd. Unit 3A

Guilford, CT 06437

frontdesk@shorelinechildrensdental.com

P: (203)533-5050

F: (203)689-5146

*If possible, we prefer records and radiographs (in JPEG format) to be sent digitally to the above email address- thank you!*

Parent/Guardian signature _____