



**Mount Auburn Dental**

JAMES HELMKAMP, DDS, MAGD

Date: \_\_\_\_\_

Dr. \_\_\_\_\_

I authorize the release of the following patient record(s) and x-rays:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to the office of:

Mount Auburn Dental  
James F. Helmkamp, DDS, MAGD  
227 Mount Auburn Avenue  
Auburn, ME 04210

\*\*\*records/xrays can be emailed to: [debbie@mountauburndental.com](mailto:debbie@mountauburndental.com)

Signature \_\_\_\_\_