Mount Auburn Dental

JAMES HELMKAMP, DDS, MAGD

Date: ________________

Dr. ____

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

____
Name   DOB:
____

____

to the office of:

Mount Auburn Dental
James F. Helmkamp, DDS, MAGD
Tyler J. Gagnon, DMD
227 Mount Auburn Avenue
Auburn, ME 04210

***records/xrays may be emailed to: debbie@mountauburndental.com

Signature ______________________________