Mount Auburn Dental
Dental Care Experts

Date: _____

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

_____ _____
Name DOB:

From the office of: _____
Phone: _____
Email: _____

To the office of: Mount Auburn Dental
Tyler J. Gagnon, DMD
227 Mount Auburn Avenue
Auburn, ME 04210
207-782-3971

*** records/x-rays may be emailed to: **info@mountauburndental.com**

Signature: _____