Robert D. Morlan
DMD
Family & Cosmetic Dentistry

RELEASE OF RECORDS TO DR. ROBERT D. MORLAN, DMD

Please allow this letter to act as authorization to release all my records and X-rays to the office of Robert D. Morlan, DMD. Please send before my appointment date of:

_____

Patient Name: _____

DOB: _____

If you cannot email, please send them by USPS to:

Robert D. Morlan, DMD
225 Water Street Ste. B100
Plymouth, MA 02360

Thank you for your time.

_____ _____
Patient/Guardian Signature Date