

**Norwich Smiles Family Dentistry, LLC**  
**Dr. Demetrios Petropoulos, D.M.D.**  
**Dr. Edgar A. Heil, D.M.D.**

**514 West Main St.**  
**Norwich, CT 06360**  
**860-889-5166**

**REQUEST FOR RELEASE OF RECORDS**

I hereby authorize the release of a copy of my dental records and most recent xrays to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
(Name and address of new dentist)

**Please allow 30 days for records to be transferred.**

\_\_\_\_\_  
(Name of patient, please print)

\_\_\_\_\_  
(Date of birth of patient)

\_\_\_\_\_  
(Signature of patient or legal guardian)

\_\_\_\_\_  
(Date)