Merrimack Dental Associates
P.O. Box 189
Merrimack, NH 03054
603-424-6131
Fax: 603-424-3620

Record Release Request

I, _____ DOB: _____am requesting that my current radiographs be forwarded to the following dental office.

Merrimack Dental Associates

Email: **office@merrimackdental.com**

Patient/Guardian Signature: _____Date: _____