Meng-Chieh Lee D.D.S., M.M.Sc.

BRAIDC Beverly Restorative and Implant Dentistry Center

Authorization for Release of Dental Records and Dental Radiographs

Date: _____

Dr. _____

Dentist from who you are requesting x-rays.

I, _____,

Please print, patient name or guardian name if under 18,

hereby authorize the release of _____'s

Patient, please print

dental records and dental radiographs to:

Beverly Restorative and Implant Dentistry Center
Dr. Meng-Chieh Lee D.D.S.
100 Cummings Center Suite 128-Q
Beverly, MA 01915
Phone: 978-232-9003 Fax: 978-232-9034 E-mail: office@braidc.com

Patient signature: _____ Date: _____

(Guardian signature if under 18)

Please forward the appropriate records and radiographs preferable by e- mail or postal mail if necessary so they will be available for my appointment on _____ at the BRAIDC office.

Thank you.