

PAUL J.R. GAMACHE, DMD, PC
137 ELM STREET
PITTSFIELD, MA. 01201
(413)442-8664
info@paulgamachedmd.com

Record Release Form

Date: _____

Patient: _____

Address: _____

DOB: _____

I grant permission to Dr. _____ to release to

_____ complete information concerning dental

finding and treatment of the above named patient. I release

Dr. _____ from any laws related to disclosure of

confidential or privileged information.

Signature: _____ Date: _____