

REQUEST FOR RELEASE OF PATIENT RECORDS

**Wayland Family Dental Center
Michael A. Putt, D.M.D.
16 Boston Post Road
Wayland, MA 01778**

Date: _____

Request for copy of records and x-rays:

Name: _____

Address: _____

City, State, Zip: _____

Signature: _____

Please Send Records to:

**Wayland Family Dental Center
Michael A. Putt, D.M.D.
16 Boston Post Road
Wayland, MA 01778**

Phone: (508) 358-6108

Fax: (508) 358-6138