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Ivelina N. Dean, D.M.D
Simon Bangiyev, D.M.D.
Dawn Weldon, D.M.D.

New Haven Dental Group LLC

I, _____, hereby authorize the release of my records including copies of radiographs and daily treatment notes from the address below so that they may be forwarded to the New Haven Dental Group.

Name and address of previous dental office:

Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____

Patient's Name: _____
Date of Birth: _____
Today's Date: _____

_____
Patient's Signature

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Fax: (203) 781-8089

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Tel: (203) 488-0091
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Please email x-rays to info@newhavendental.com

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New Haven, CT 06511
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