



1147 Main Street  
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## RECORD RELEASE FORM

**PLEASE FILL OUT AND SEND TO PREVIOUS DENTAL OFFICE.**  
IT WOULD GREATLY HELP US TO HAVE DENTAL RECORDS PRIOR TO DENTAL VISIT.

Date \_\_\_\_\_

To \_\_\_\_\_  
(Doctor)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize the release of dental records, or copies of such, and request that they be transferred to:

Steven C. Demetriou, D.M.D.  
1147 Main Street, #204 - Cottage Place  
Tewksbury, MA 01876  
(978) 851-6334

Please e-mail digital x-rays to [info@drdemetriou.com](mailto:info@drdemetriou.com)

\_\_\_\_\_  
Please print your name (Parent/Guardian)

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Date of Birth