



Date: _____

I hereby authorize:

To release my radiographs and records to:

Dr. Matthew Heimbach & Dr. Timothy Ahern
Abenaki Dental Care, PLLC
One Hampton Rd Suite #305
Exeter, NH 03833
Phone: (603)583-4533 Fax: (603)583-4507
Or email to: frontdesk@abenakidentalcare.com

Patient Name: _____ DOB: _____

Address: _____

Signature: _____ Date: _____