LAURIE A. ROSATO, DMD
6 Loudon Road Suite #2
Concord, NH 03301
Telephone (603)228-9276
Fax (603)228-7305
info@laurierosatodmd.com

I, _____, with a date of birth of _____,

hereby authorize and request that my dental radiographs and records be transferred to:

Laurie A. Rosato, D.M.D., PLLC
6 Loudon Road, Suite #2
Concord, NH 03301
info@laurierosatodmd.com or
rdh@laurierosatodmd.com (If using Send Inc for secure messages)

_____ _____
Signature of Patient **Date**
(or parent/guardian if under 18 years of age)

This patient is scheduled with our office on _____.