



Dear _____,

Please release all dental records for _____
to Drs. Hadden & Whidden including x-rays, treatment sheets and date of last prophylaxis.

Please email x-rays to vernon@haddenwhidden.com in Dexis or jpeg format only.

Patient Name: _____

Address: _____

Date of Birth: _____

Patient Signature

Date

Drs. Hadden, Whidden 219 Talcottville Road, Vernon CT. 06066

860-872-2004 Fax 860-872-3550