



Dear _____,

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

Please send email to: vernon@haddenwhidden.com OR coventry@haddenwhidden.com
in DEXIS or jpeg format only.

Patient Name: _____ Date of Birth: _____

Address _____

Patient Signature

Date

Drs. Hadden & Whidden

219 Talcottville Road

Vernon, CT. 06066

P: 860-872-2004 F: 860-872-3550

Drs. Hadden & Whidden

1679 Boston Turnpike

Coventry, CT. 06238

P: 860-742-7065 F: 860-742-8760