Vora Dental Care

Carina V. Vora, DDS, Diplomate, ABDSM
American Board of Dental Sleep Medicine

Release of Dental Records

Name of Prior Dentist: _____ City:_____

Prior Dentist Phone: _____ Fax: _____

I _____, hereby give permission to release copies of my dental records for the purpose of patient care to Carina Vora, DDS. **I am aware that there is some level of risk that third parties might be able to read unencrypted emails.** I release you from all legal responsibilities and liability that may arise from this authorization.
Please mail to:

Vora Dental Care
12 Case St. Ste. 204
Norwich, CT 06360
Or email to: office@voradentalcare.com

Type of records requested:

- Copies of dental radiographs
- Entire dental record
- Current treatment plan

Signature_____ Date: _____

Patient's Name _____ DOB: _____

Address _____

Date of last radiographs to be forwarded:

FMX: _____ Pano: _____ BWX: _____