Andrew Ponichtera, D.M.D., M.S.

Prosthodontist

Date: _____

To: _____

_____

_____

Re: _____

_____

_____

_____

I, _____, authorize the release of my dental records including visit notes, x-rays, and any other information pertaining to my treatment there to the office of:

Dr. Andrew Ponichtera
PO Box 316
Weatogue, CT 06089

Phone: 860-651-3319
Fax: 860-651-3314
ajponichteradmdms@comcast.net

Please forward any digital x-rays in DEXIS (preferred) or JPEG format to the above noted email address.

Regards,

_____