

**Richard J. Haskell D.M.D, PC**  
**35 High School Road Ext.**  
**Hyannis, Ma 02601**  
**Phone (508) 775 0622**

Records Release Form

I, \_\_\_\_\_, DOB: \_\_\_\_\_ give authorization for  
\_\_\_\_\_ to release my dental records/x-rays to the office of  
Richard J. Haskell, D.M.D for my continued treatment.

Please email records to: [rjhaskelldmd@outlook.com](mailto:rjhaskelldmd@outlook.com)  
Or mail to: 35 High School Road Ext, Hyannis, MA 02601

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient name – Print

\_\_\_\_\_  
Patient name – Sign