

# Dawn Cooley, D.M.D.

**Select Office Location:**

36 Main Street, Rt. 4  
Unionville, CT 06085  
860-673-9770

124 New Hartford Road  
Barkhamsted, CT 06063  
860-921-0191

**Or email to: [xray@dawncooleydmd.com](mailto:xray@dawncooleydmd.com)**

Date \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to provide Dawn Cooley, D.M.D. with copies of dental records with respect to any dental care and treatment. I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatment, prognosis and copies of any and all other records, including radiographs, which pertain to me.

\_\_\_\_\_  
Patient Signature/ Legal Guardian Signature

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Phone \_\_\_\_\_