Dental Records Release Form

Patient Name: _____

I do hereby request and give permission to release my Dental Records for the following time Period:

___ / ___ / _____ To ___ / ___ / _____

From the following Dental Office:

Name : _____

Address : _____

City : _____

State : _____ Zip : _____

Office Phone : _____

Please Release the above mentioned Dental Records to:

Name: Alden Family Dentistry

Address: 13367 Broadway

Alden, NY 14004

Office Phone: 716-937-7812

Digital Films can be emailed to: **soltizdentistry@gmail.com**

Printed Patient Name: _____

Date of Birth: ___ / ___ / _____ Social Security#: _____

_____

Patient Signature