RECORDS RELEASE REQUEST

Date: _____

To: _____
_____
_____

I authorize the release of my dental records, including x-rays and request that they are transferred to:

Halfmoon Family Dental
1456 Vischer Ferry Rd.
Halfmoon, New York 12065
(518)348-1999
Fax: (518)373-8159
E-mail- info1@halfmoonfamilydental.com

Signature: _____
Print Name: _____