Four Executive Park Drive
Albany, NY 12203
Phone: (518) 489-6972
Fax: (518) 446-1824

Record Release

I hereby authorize and request you to release my child's dental records to:

_____

_____

_____

_____

Patient(s) Name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____

Reason for request

Moving _____ Second Opinion _____

Other, please explain: _____

_____

Parent/Guardian Signature: _____

Date: _____/_____/_____

Contact Number: _____-_____-_____

Please allow 5 business days for records to be release.
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