PATIENT RECORDS RELEASE REQUEST

Date:_____

To: _____
(PREVIOUS DENTIST)

I hereby authorize the release of copies of pertinent written records and x-rays for the following patient:

Name of Patient: _____DOB_____

Current Address _____

_____

Phone Number _____

I authorize transfer of the records to:

Thomas F. Cingel, DDS, PC
379 Broadway
Kingston, NY 12401
845-331-1085
DRCINGEL@GMAIL.COM

_____ _____
Signature of patient or guardian, if applicable Date

_____
Printed name of signee