RECORDS RELEASE AUTHORIZATION

To

_____
_

DOCTOR OR HOSPITAL

_____
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ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY DENTAL RECORDS AND X-RAYS TO:

Gary DiSanto-Rose, D.M.D.
32 South Market Street
Johnstown, New York 12095
(518) 762-7033

NAME _____ DATE_____

ADDRESS _____

SIGNATURE _____
(IF RELATIVE, STATE RELATIONSHIP)