

RECORDS RELEASE REQUEST

Date _____

Dr. _____

Address _____

City _____ State _____ Zip _____

I authorize the release of my/our dental records and request that they be transferred to:

Alan M. Kasperowski, D.D.S.
Bryan M. Kasperowski, D.M.D.
FAMILY DENTISTRY
79 Broad Street
Westfield, MA 01085
(413) 562-5494

Patient Name

Signature (patient, parent or guardian)