RECORDS RELEASE AUTHORIZATION

I hereby authorize:

_____

Dentist Name

_____

Address

_____

City, State, Zip Code

to send copies of the dental records and radiographs of:

_____

Patient Name Date of Birth

_____

_____

Send Records to:

KASPEROWSKI FAMILY DENTISTRY
79 Broad Street
Westfield, MA 01085

Tel: 413-562-5494
Fax: 413-568-5597

_____

Patient, Parent or Guardian Signature Date