RECORDS RELEASE REQUEST

Date_____

To_____
(Doctor)

Address_____

City_____State_____Zip_____

I authorize the release of dental records, including x-rays and request they be transferred to:

Parkview Family Dentistry of Halfmoon, PLLC
173 Rte 236
Halfmoon, NY 12065
Telephone (518) 664-2500
amy@parkviewfamilydentistry.com to email records

_____ _____
(Print Name) Signature