

The Fleischer Dental Group, P.C.

2085 Bellmore Ave., Bellmore, NY 11710
516.826.3520

RECORDS RELEASE/ REQUEST

To: _____
(Doctor/Hospital)

Address: _____

City _____ State _____ Zip _____

I hereby authorize the release of my Records/ X-rays or copies of such and request they be transferred to:

Name: _____

Address: _____

City _____ State _____ Zip _____

Print Name of Patient

Date Records Sent: _____

Patient's Signature

Date