RECORDS RELEASE REQUEST

TO: _____

(Name of Former Dentist or Practice)

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

I hereby authorize the release of my dental records, x-rays or copies of such and request that they be transferred to:

DR. BETH HENDLIN DDS

VALATIE MEDICAL ARTS BUILDING

SUITE 203

VALATIE NY, 12184

PHONE: 518-758-9291

FAX-518-758-9262

EMAIL: DOCB@NYCAP.RR.COM

_____

(Patient Signature)

_____

(Print Name)