X-Ray / Record Release Form

To Whom It May Concern:

I ______________________ authorize you to release my patient records and dental radiographs to:

Joseph J. Russo, DDS
47 William Street
Lyons, NY 14489
315-946-6511

Digital radiographs may be sent to:

info@russo-family-dental.com

Thank you very much for your timely consideration in this matter.

Name of PREVIOUS Dentist / Practice_________________

Signature________________

Date____________________