REQUEST FOR RELEASE OF PATIENT RECORDS

I hereby authorize the release of dental records and xrays or copies of such for the patient listed below to be transferred to the dental office of:

Rush Family Smiles
Dr. Rush Hejazi
15 High Tech Drive
Rush, NY 14543
585-321-1460
info@rushfamilysmiles.com

Patient's Name: ____

DOB: _____________________

Previous Dental office:

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______________________________________ _________________

Patient/Parent/Guardian Signature Date

We thank you in advance for help and cooperation in this matter.