WASHINGTON SQUARE DENTAL GROUP, P.C.

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TWO FIFTH AVENUE, SUITE 4 – NEW YORK, N.Y. 10011

TEL: 212-674-4011 - EMAIL: WASHINGTONSQUAREDENTALGROUPNYC@GMAIL.COM

REQUEST TO RELEASE DENTAL RECORDS AND X-RAYS

Date: _____

Patient Name: _____

(Please print clearly)

To Whom It May Concern,

I, _____ hereby authorize the release of my dental records and xrays. Please send them to the offices of:

Washington Square Dental Group
Dr Mark Horowitz – Dr Kori Darling – Dr Anne Truong
2 Fifth Avenue, Suite 4 – New York, N.Y. 10011

Note: Please send e-mails containing x-rays in JPEG/DEXIS formats only to washingtonsquaredentalgroupnyc@gmail.com

If there are any questions, please give me a call at: _____

Sincerely,

_____

Patient Signature