RECORDS RELEASE AUTHORIZATION

TO:

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I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE MY RECORDS AND XRAYS TO PLOSKY DENTAL LLP., VIA EMAIL TO:

PLOSKYDENTAL@GMAIL.COM

IF EMAIL TRANSMISSION IS NOT AVAILABLE FOR XRAYS OR RECORDS, PLEASE MAIL SAME TO:

PLOSKY DENTAL
233 EAST JERICHO TURNPIKE
HUNTINGTON STATION, NY 11746
TELEPHONE: 631-427-4327

PLEASE SEND THE COMPLETE HISTORY RECORDS IN YOUR POSSESION, INCLUDING XRAYS, SCANS, TEST RESULTS CONCERNING MY DENTAL TREATMENT FROM THE PERIOD OF ___________________ TO _______________________

THANK YOU IN ADVANCE FOR YOUR COURTESY AND COOPERATION IN THIS MATTER.

NAME:____

ADDRESS:____

SIGNATURE:______________________________________

DATE:____________________________________