

DATE: _____

RECORDS RELEASE AUTHORIZATION

DOCTOR

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

**COUNTRYSIDE DENTAL
42 KINDERHOOK STREET
CHATHAM, NY 12037
Ph. 518-392-5231
Fax 518-392-7339**

DOMENIC RICCOBONO, D.D.S. VICKI COHN, D.D.S.

ALL RECORDS AND X-RAYS CONCERNING MY CARE.

NAME: _____

ADDRESS: _____

SIGNATURE: _____

WITNESS: _____

Confirmed: _____

By: _____

FAXED: _____

BY: _____