RECORD RELEASE AUTHORIZATION

To: _____
DOCTOR OR HOSPITAL

_____
ADDRESS/TELEPHONE

I herby authorize and request the release of:

- ❑ The complete history
- ❑ Records
- ❑ Copy of X-rays

To:

NORTH SHORE DENTAL GROUP
450 PLANDOME ROAD
MANHASSET, NY 11030
516-627-3535

Patient Name: _____

Address: _____

Patient Signature: _____

Date: _____