115 South School Street • Bellefonte, PA 16823 • (814) 355-1587

Records Release Authorization

Please mail this to your former dentist

Date:_______________________

Dear Doctor_______________________________:

I am requesting that you please send my/my family's current records/ radiographs to the following dental practice:

Bellefonte Family Dentistry
115 South School Street
Bellefonte, PA 16823

PATIENT: ___________________________________ **Date of Birth:** ____________

PATIENT: ___________________________________ **Date of Birth:** ____________

PATIENT: ___________________________________ **Date of Birth:** ____________

PATIENT: ___________________________________ **Date of Birth:** ____________

Sincerely,

____

(Patient's signature) (Patient or guardian if patient is a minor) (Date)