RECORDS RELEASE REQUEST

Date _____

To _____

(Doctor)

Address _____

City _____ State _____ Zip _____

I authorize the release of dental records, full mouth radiographs and bitewings relevant to dental treatment, or copies of such, and request that they be transferred to:

Gina Prokosch-Cook, D.D.S.
45 Quassaick Avenue
New Windsor, N.Y. 12553
Ph: 845-569-8900

***If Radiographs are digital, please e-mail them to DrCook@thedentaldreamteam.com**

_____ _____

Printed name of Patient(s) Signature (patient, parent or guardian