

RECORDS RELEASE REQUEST

To: _____

Address: _____

City: _____ State: _____ Zip _____

Phone: _____

Fax: _____

I hereby authorize the release of my current records/x-rays or copies of such and request that they be transferred to:

Gerard L. Gonsalves, DMD, PA
2168 Millburn Ave., Suite 102
Maplewood, NJ 07040
Phone: 973-763-1300
Fax: 973-763-0800
www.maplewoodsmiles.com

(Print name of patient)

(Patient or Guardian signature)

(Date)