RECORDS RELEASE REQUEST

To: ________________________________
(name of previous dentist)
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
E-Mail: glgdmd@comcast.net
www.maplewoodsmiles.com

____
(Print name of patient)

____
(Patient or Guardian signature) (Date)