Authorization for the Release of Dental Records and X-rays

Date: _____

Transfer records from:

_____
(Previous dental practice name)

_____
(Previous dental practice address)

_____
(Previous dental practice city, state, zip)

I, _____, DOB_____,
(Your name)

request the release of my dental records to Dr. Kathy T. Knox DDS/Dr. Alexander J. Knox DDS at Otego Family Dental P.C..

Please forward records to the address below. Please send radiographs (x-rays) via eMail to Records@OtegoFamilyDentalPC.com

I specifically request that you release copies of current X-rays and treatment notes.

Thank you for your time and cooperation with this matter.

Patient's Signature: ----------

374 Main St., PO Box 334, Otego, NY 13825 429 Main St, Oneonta, NY 13820
(607) *988-6555* (607) 988-2761 Fax (607) 433-2037