Records Release Authorization

To: _____
Previous Dentist's Name

Dentist's Address: _____

_____

Dentist's Phone Number: _____

I hereby authorize and request you to release to:

Stonebridge Dental
781 Far Hills Drive, Suite 500
New Freedom, PA 17349
Telephone: (717) 235-8234
Fax: (717) 235-8266
info@stonebridgedental.net

The complete history records in your possession, concerning any treatment from the beginning of my first treatment to the present.

Patient Name: _____

Patient Signature: _____