# RECORDS RELEASE AUTHORIZATION

TO: _____
Previous Dentist name

ADDRESS _____TEL #_____
Previous Dentist address

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:


Jeffrey S. Rubin D.D.S.
Olivia C. Quinn, D.D.S.
265 Main Street
Northport, New York 11768
Tel 631-754-1107
Fax 631-754-1108
Email address NORTHPORTFAMILYDENTAL@GMAIL.COM

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

Your Name_____D.O.B_____

Other family members requested please list below :

Address_____Phone#_____

Signature of patient _____