AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Date_____

I_____

Hereby give permission for release of my dental records including x-rays.

Copies from:

Dr._____

Street Address_____

City, State, Zip Code_____

Please send to: Dr. Olivia Masry – olivia.masry@briardent.com

Dr. Joyce Lockwood – joyce.lockwooddds@briardent.com

Patient's Name_____

Signature_____

Street Address_____

City, State, Zip Code_____

OLIVIA MASRY D.D.S. & JOYCE LOCKWOOD D.D.S., P.C.
312 CHAPPAQUA ROAD
BRIARCLIFF MANOR, NY 10510
PHONE: 914-762-4422