CONSENT TO RELEASE PATIENTS RECORDS

PATIENT INFORMATION (Please Print):

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home | Cell #: _____

RELEASE TO MY MOST RECENT RADIOGRAPHIC RECORDS:

TO:

Name: _____

Address: _____

Phone #: _____

FROM:

Michael Messana D.M.D.
Hudson County Orthodontics
Location: Bayonne | Jersey City | Wallington
Phone #: (201) 653-4474
Fax #: (201) 623-3500

BY MY SIGNATURE I AUTHORIZE THE RELEASE OF MY RECORDS.

_____ _____
Patient Date