SCHUTZE FAMILY DENTISTRY P.C.

A Smile Is A Valuable Resource

Records Release Authority

Date _____

To _____
(Doctor Name)

Address _____

City _____ State _____ Zip _____

I hereby authorize the release of my x-rays and records to be transferred to:

Schutze Family Dentistry
453 Dixon Road, Suite 3
Queensbury, NY 12804
Phone: 518-793-3553
Fax: 518-793-5695

_____ _____
Print name of patient Patient signature

Please email to: geri@schutzefamilydentistry.com