"A Smile Is A Valuable Resource"

Schutze Family Dentistry

RECORDS RELEASE AUTHORITY

Date _____

To: _____
(Doctor)

Address: _____

City: _____ State: _____ Zip: _____

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

Schutze Family Dentistry
453 Dixon Road, Suite 3
Queensbury, NY 12804
Tel (518) 793-3553
Fax (518) 793-5695

_____ _____
(Print name of patient) Signature (patient, parent or guardian)

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