SPA DENTAL, P.C.

68 Milton Avenue
Ballston Spa, N.Y. 12020

(518) 885-1791
Fax (518) 490-4276

Authorization to Release Dental Records

Patient's Name: _____

Date of Birth: _____

Address: _____

Authorization for Release: I hereby authorize _____
(name)

_____
(address) (phone)

to release, disclose and deliver all dental radiographs and medical records to:

Authorized Recipient:
Spa Dental, P.C.
68 Milton Ave
Ballston Spa, NY 12020
Email: spadental@officedental.net
Fax: 518-490-4276

Patient or Parent's Signature _____

Date: _____