Applegate Dental, PLLC
2177 Union Road • West Seneca, NY 14224
www.Applegatedentalpllc.com • 716.668.4646

RECORDS RELEASE/REQUEST

_____(DOCTOR/FACILITY)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

I hereby authorize the release of my x-rays or copies of such and request that they be transferred

☐ TO ☐ FROM (PLEASE CHECK ONE)

APPLEGATE DENTAL, PLLC

applegatedental@gmail.com

NAME OF PATIENT: _____ (PLEASE PRINT)

DATE OF BIRTH: _____

DATE OF X-RAYS FROM: _____ TO: _____

PATIENT'S/GUARDIAN'S SIGNATURE: _____ DATE: _____