RECORDS RELEASE REQUEST
(INCOMING PATIENTS)

DATE____

TO____

ADDRESS ____

CITY____________________STATE__________ZIP_______________

I authorize the release of dental records (including x-rays and chart notes) and medical records, or copies thereof, and request that they be transferred to:

MITCHELL M. STRUMPF, D.D.S., P.A.
2389 Ringling Boulevard, Suite C
Sarasota, Florida 34237
Telephone: (941) 957-3311

A Fax or photo copy of this letter may serve as an original.

____
Print Name of Patient

____
Signature (patient, parent or guardian)

doc: word/office/record1