

RECORDS RELEASE REQUEST  
(OUTGOING AND REFERRED OUT PATIENTS)

DATE \_\_\_\_\_

TO Mitchell M. Strumpf, D.D.S., P.A.

ADDRESS 2389 Ringling Blvd. Suite C

CITY Sarasota STATE Florida ZIP 34237

I authorize the release of dental records and medical records, or copies of such, and request that they be transferred to:

DOCTOR \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

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

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature (patient, parent or guardian)