Records Request Release

Date: _____

To: _____
(*Dentist*)

Address: _____

City: _____ State: _____Zip: _____

Phone: _____ Fax: _____

E-mail:_____

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

Skelly Smiles

Elizabeth Skelly, DMD PC

1625 Northampton Street

Easton, PA 18042

Phone: *(610)252-8966*

Fax: *(610)252-6691*

E-mail: *info@skellysmiles.com*

Print Name of Patient Date of Birth

Signature (Patient, Parent or Guardian)

SKELLY SMILES
FAMILY, COSMETIC & IMPLANT DENTISTRY