

RECORDS RELEASE REQUEST

Date _____

To _____
(Dentist's Name)

Address _____

City _____ State _____ Zip _____

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

Maher Kasabji, **D.D.S.**

Zorica Engelhardt, **D.D.S.**

150 Hazard Ave, Just Off Exit 47e, Enfield, CT 06082
(860) 763-5522

Print Name of Patient

Signature (patient, parent, or guardian)