MEDICAL RECORDS RELEASE FORM

I authorize the office of

_____

to send a copy of my medical records and radiographs to:

Gary L. Sandler,DDS & Bonnie E. Lipow, DDS

201 Moreland Road, Suite #8 Hauppauge, NY 11788

Tel: 631-499-1800

Fax: 631-864-7131

SandlerDDSLipowDDS@gmail.com

Patient's
Name_____

Patient's
Address_____

Patient's Telephone Number: _____

Patient's E-mail address: _____

A copy of this authorization is as valid as the original. This authorization will remain in effect until I revoke this authorization in writing.

_____ Date: _____

Signature (Parent or guardian if minor)