Records Release Request

Date: _____

To: _____

Address: _____

City, State, Zip: _____

Phone: _____

E-Mail: _____

Fax: _____

I authorize the release of my dental records (copies of radiographs) to:

Premier Dentistry
Anna Meyerson, DMD, PC
Goshen Village
1544 Paoli Pike
West Chester, PA 19380
Tel. (610) 696-7066
Fax: (610) 696-0969

Digital X-rays may be emailed to premierdentisty1@comcast.net (jpg or dexis format please)

_____ _____
Print name of patient Signature (patient, parent or guardian)

_____ _____
Patient's phone number Social Security Number