Perth Dental Office

Dr. Denise Mastroianni-Gleason

5010 State Highway 30, Suite 102. Amsterdam, NY 12010

Phone: 518-843-0200 Fax: 518-843-1532

Email: perthdentaloffice@yahoo.com

Record Release Authorization

To:_____

_____

_____

I hereby request and authorize the release of my clinical records and radiographs concerning my past dental tratment at your office to:

Perth Dental Office
5010 State Highway 30, Suite 102
Amsterdam, NY 12010

Patient(s) Name:_____DOB_____
Patient(s) Name:_____DOB_____
Patient(s) Name:_____DOB_____
Patient(s) Name:_____DOB_____

Signature:_____
Date:_____