RECORDS RELEASE REQUEST

DATE:_____

TO:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

I authorize the release of copies of all my dental records and request that they be sent to:

ADAM N. STILL, D.M.D., P.L.
MITCHELL M. STRUMPF, D.M.D.
2389 RINGLING BLVD., SUITE C
SARASOTA, FL 34237
Phone: 941-957-3311
Fax: 941-957-3310
E-Mail: info@SmileSarasota.com

A fax or photo copy of this letter may serve as an original.

_____

Print Name of Patient

_____

Signature (patient, parent or guardian)