RECORDS RELEASE REQUEST

Date _____

To _____
(Doctor)

Address _____

City _____ State _____ Zip _____

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

Elegant Smiles of Sea Girt, LLC
Dr. William S. Steiner, D.M.D
2130 Highway 35, Suite 211
Sea Girt, NJ 08750
Phone (732)974-9494 Fax (732)974-8601
ElegantSmilesNJ@optonline.net

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

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

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