RECORDS RELEASE AUTHORIZATION

I hereby authorize and request the release of my dental records and X-rays to:

A to Z Family Dentistry, PC
Marina Guelfguat, D.D.S.
159 E. Main St., Little Falls, NJ 07424
Tel: (973) 837-6655
Fax: (973) 837-6654
Email: atozfamilydentistrynj@gmail.com

Patient's Name (Please print) _____
Address: _____
City:_____
State: _____ Zip: _____

Signature: _____
Date: _____

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