

Drs. Schaffer, Fiorentino & Associates  
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**REQUEST FOR RELEASE OF PATIENT RECORDS**

To whom it may concern,

Please send the current bitewing, panoramic and full series xrays and written records for the following patient(s) to our office:

Patient's Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

The undersigned acknowledges that they are lawfully authorized to request this release of records.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**Thank you for your prompt attention to this matter.**