FAMILY·COSMETIC·IMPLANTS
ADVANCED DENTISTRY OF CENTRE COUNTY

RECORD RELEASE REQUEST

Date: _____

RELEASE TO: _____
(Doctor)

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

I authorize the release of dental records or copies of such, and request that they may be transferred from:

Advanced Dentistry of Centre County
2014 Sandy Drive, State College, PA 16803
Telephone: (814) 238-2431 Fax: (814)235-6881
Email: info@advanceddentistrycc.com

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

___Transfer of Records ___Second Opinion ___Other, please explain _____

_____	_____	_____
Print Name of Patient	Date of Birth	Signature (Patient, Parent or Guardian)

This release expires one year from date at top.