RECORDS RELEASE REQUEST

To_____

Address_____

City_____State_____Zip_____

I authorize the release of the dental records and medical records relevant to dental treatment, or copies of such, and request the records be transferred to:

Silvestri & Deniger

2300 Gause Blvd., East

Slidell, La. 70461

(985) 641-7200

_____

Print name of patient

_____

Signature (patient, parent or guardian)