STEVEN C. STACEY, DDS
quality dentistry for your family

Dental Records Release Authorization

Patient Name :_____ Date of Birth:____/____/____

Family Members to be transferred as well :_____

_____

_____

I hereby authorize the release of my dental records and x-rays, and request they be transferred to :

Dr. Steven C. Stacey, DDS, PC

Dr. Steven J. Kolenda, DDS, PC

6702 Buckley Rd Ste 120

N. Syracuse, NY 13212

stevenstaceydds@gmail.com

_____ _____ _____

Name Signature Date

Name of previous Dentist/Phone _____

Date of last visit _____