

# STEPKA FAMILY DENTAL

*Providing the best dental care for your family, from ours, since 1973.*

## Records Release Request

Patient: \_\_\_\_\_

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

\_\_\_\_\_

I authorize the release of dental records and radiographs  
and request that they be transferred to the address below:

Stepka Family Dental, 501 Great Road, Suite 207, North Smithfield RI 02896

Signature of Patient: \_\_\_\_\_