Stepka Family Dental

Branch Village Professional Building
501 Great Road Suite 207
North Smithfield, R.I. 02896
401-766-9857
401-762-0871 fax

RECORDS RELEASE REQUEST

Patient Name: _____
Patient Address: _____
_____

I authorize the release of dental records and radiographs, and request that they be transferred to the above address or e-mailed to address below.

Signature of Patient: _____

PRIOR TREATING DOCTOR'S INFORMATION

Doctor's Name: _____
Doctor's Address: _____
_____

E-Mail: Karen@stepkafamilydental.com **or** Kristina@stepkafamilydental.com