RECORDS RELEASE/REQUEST

To_____
(Doctor/Hospital)

Address_____

City _____State _____Zip_____

I hereby authorize the release of my dental records, or copies of such, including a full set of x-rays or panorex taken within the past 5 years, and any and all checkup x-rays taken within the past 1 year, and request that they be transferred to:

Daniel Leske, D.D.S., P.C.
5895 John R Road
Troy, MI 48085
Tel: (248) 828-3091

_____
Print Name of Patient

_____
Patient Signature Date