AUTHORIZATION TO RELEASE RECORDS AND X-RAYS

Each patient must sign his/her Authorization to Release Form

Requesting records from:

Doctor: _____
Address: _____
_____
_____

Authorized to release records and x-rays to :

Doctor: **Harry Randel, DMD, PC**

Address: **9892 Bustleton Avenue**
Suite #304
Philadelphia, PA 19115
Or they can be emailed to: hrandeldmd@verizon.net

Patient Information :

Your Name: _____
_____
_____
_____

In compliance with appicable State Board regulations, please copy my dental records and send them within 14 days

Patient Signature: _____

Date: _____