RECORDS TRANSFER REQUEST

DATE:_____

TO:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP_____

I hereby authorize the release of any current x-rays and pertinent records for_____

_____
Patient Name(s)

Patient's signature_____

Please Mail to:

Howard Cetel, DDS, PA
100B Kings Way West,
Sewell, NJ 08080