J. Paul Keelan, D.M.D.

Records Release Request

*TO*_____

*ADDRESS*_____

*CITY*_____*STATE*_____*ZIP CODE*_____

I HEREBY AUTHORIZE THE RELEASE OF MY DENTAL RECORDS

AND ANY X-RAYS OR COPIES OF SUCH AND REQUEST THAT THEY BE

TRANSFERRED TO:

J. Paul Keelan, D.M.D.
Avada Building – Second Floor
1022 North Main Street
Butler, Pennnsylvania 16001

(724) 285-4153

_____
Print Name of Patient

_____
Address of Patient

_____
PATIENTS SIGNATURE DATE