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. I request that they be transferred to:

Keelan Dental
264 New Castle Rd.
Butler, PA 16001
724-285-4153
scheduling@keelandental.com

Patient: _____

Address: _____

_____

_____

Patient or Guardian Signature **Date**