COCOZZO FAMILY DENTISTRY

DR. CHRISTINA COCOZZO

4 HEMPHILL PLACE, SUITE 151, MALTA, NY 12020

cocozzofamilydentistry@live.com

PHONE: 518-899-5800   FAX: 518-899-5847

RECORDS RELEASE AUTHORIZATION

I ____________________________________ authorize the release of dental records, including dental X-rays and request they be transferred to the above address or email address:

Patients Name: ____ DOB______________

Patients Name: ____ DOB______________

Patients Name: ____ DOB______________

Patients Name: ____ DOB______________

Signature: ____

Previous Dentist Name: ________________________________

Phone #: -____________________________________

Address: ____

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