Patient Records Release Request

Date: ___________________________

To: Gail C. Thornton, D.D.S.
160 Main St.
Saugerties, NY 12477
(845) 418-6564

I hereby authorize the release of copies of pertinent written records and x-rays for the following patient:

Name of Patient: ____ D.O.B.:________________

Current Address: ____

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Phone Number: ____

I authorize transfer of the records to:

Name of Office: ____

Address: ____

Phone Number: __________________Email address ____________________________________

____ ___________________________
Signature of patient or guardian, if applicable Date

____
Printed name of signee

Return completed request to Dr. Thornton either via mail [160 Main St., Saugerties, NY 12477], fax [(845) 414-8382] or email [drgthornton@gmail.com]