WOODBINE DENTAL

901 DeHirsch Ave
Woodbine, NJ 08270
Phone (609) 861-2784
Fax (609) 861- 3160

Records Release Form

Date:

Patient's Name :

Address :

I am the patient, or the legally authorized representative of the patient(s), listed above. I request Woodbine Dental to release my protected dental information, (or the patient(s) listed above) including any radiographs to:

_____ _____

Print Name of Patient or Guardian Patient/Guardian Signature