RECORDS RELEASE/REQUEST

TO____
(DOCTOR)

ADDRESS____

CITY________________________STATE_______ZIP________

I hereby authorize the release of my ________________________

_____________________ or copies of such and request that they be

transferred to:

ROBERT M. DUTTON, D.D.S., F.A.G.D.
275 STATE ROUTE 375 SUITE 1
WEST HURLEY, NY 12491
Ph. 845-679-9744
Fax 845-382-9792

____
Print Name of Patient Date of Birth

From:________________________ To:________________________
Date of Records

____
Patient's Signature Date

NOTE: Records can be transferred electronically to the following ---
admin@robertduttondds.com