Request For Release Of Records

Date: _____

Dental Office: _____

You are hereby authorized to release *any and all* records including x-rays pertaining to your treatment of:

Patient's Name: _____

Please forward to: Scot Ioset, DDS
34 Broad St
Hamilton, NY 13346

This is a digital office, records may also be forwarded to our secure email: HamiltonDental@AspidaMail.com

Thank you in advance for your assistance in this matter.

Patient's Signature: _____

Witness: _____