
RECORDS RELEASE FORM

HYALC R_ & Associates
2590 Park Center Boulevard Suite 100
State College, PA 16801
(814) 234-6826

Please mail this to your former Dentist

Date: _____

Dear Doctor _____:

I am requesting that you please send my/my family's current records/ radiographs to the following dental practice:

White, Roan & Associates
2590 Park Center Boulevard Suite 100
State College, PA 16801
(814) 234-6826

PATIENT: _____ **Date of Birth:** _____

PATIENT: _____ **Date of Birth:** _____

PATIENT: _____ **Date of Birth:** _____

PATIENT: _____ **Date of Birth:** _____

Sincerely,

(Patient's signature)

(Date)