Victor Dental Care PLLC
6536 Anthony Drive - Suite A
East Victor Place
Victor, NY 14564
585-924-8940
www.victordentalcare.net

REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby request that you release the following patient's records:

Patient's Name:

D.O.B.:

Address:

______________________________ ________________________Print Name

______________________________ ___________________________Date
Guardian (if applicable)

Please include progress notes along with radiographs. **We are able to accept digital radiographs and images via e-mail at drtornatore@victordentalcare.net.** We thank you in advance for your assistance and cooperation in this matter.