Cathleen I. Kowalski, D.M.D.
Glenn F. Koehler, D.D.S.
Sharon P. Soria, D.M.D.

192 Main Street, Manchester, CT 06042
Phone: (860) 649-4655 • Fax: (860) 646-3281
www.pediatricdental.com

PEDIATRIC DENTAL ASSOCIATES, P.C.

Records Release

I hereby authorize and request you to release to:

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The complete dental records, including all x-rays, in your possession concerning the treatment of:

Patient(s) Name	D.O.B.

Reason for transfer:

____

Signature: ________________________________

Relationship: ______________________________

Date: ____________________________________