PATIENT RECORD RELEASE REQUEST

I, ____ request that Nester & Mathias Dental Associates, P.C., send a copy of my dental records and radiographs to the address below:

Dentist's Name ___________________________________

Dentist's Address ___________________________________

____

Phone ___________________________________

E-mail ___________________________________

Patient's Name (Print) ___________________________________

Signature ___________________________________

Date ___________________________________

Please return completed form to:

Nester & Mathias Dental Associates, P.C.
1851 Center Street
Camp Hill, PA 17011
FAX 717-761-5477
e-mail – Julie@NesterandMathias.com