STEPHEN R. ENGEL DDS
ROBERT F. CLARK DDS
MICHAEL J. ROMANO DDS
MICHAEL S. GROSSMAN DDS
BONNIE PAYER DMD

7555 Morgan Road
PO Box 2645
Liverpool, NY 13089-2645
(315) 457-0620

CONSENT FROM PATIENT TO RELEASE DENTAL RECORDS

I hereby consent to the release of a copy of the dental records for:

Patient's name: ______________________________ Date of Birth ____/____/____

Patient's address: ____

____

☐ FROM the office of Drs. Engel, Clark, Romano, Grossman & Payer

to: ___Myself
___the office of Dr. ______________________________

☐ TO the office of Drs. Engel, Clark, Romano, Grossman & Payer

____
(Printed name of patient)

X______________________________
(Signature of patient or legal guardian)

Date______________________________