**MEDICAL RECORDS RELEASE FORM**

I,                                                               , (Print Your Name) hereby authorize you to release any and all **RECORDS, *including CLINICAL NOTES and X-RAYS*** pertaining to dental care for:

TO: Vincent Fuschino, DDS

172 S. Central Avenue

Mechanicville, NY 12118

Phone: (518)664-4903

vince.fuschino.dds@gmail.com

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: ­­­\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_