CHRISTINE HOEPLINGER, D.D.S. ©

GENERAL DENTISTRY FOR THE FAMILY

Date : _____

Name: _____
(Please Print)

DOB: _____

AUTHORIZATION: I hereby authorize _____

Address: _____

_____

Phone Number: _____

to release my dental records, including recent X-Rays to:

Christine Hoeplinger, D.D.S.
3626 Seneca St.
West Seneca, NY 14224

_____
Patient Signature