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Westsidedental@nnymail.com

Westside Dental
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Utica,NY 13502
Ph: 315-266-0000
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westsidedental.utica@gmail.com

I, _____ give permission to Westside Dental to release copies

of my records/ x-rays to _____.

I understand that it can take up to five business days to duplicate my records. Please include all names of patient records to be copied. Printed copies of records will incur a charge of $0.75 cents per page. Digital copies that are emailed will be provided at no charge.

1._____

2._____

3._____

4._____

5._____

Today's Date: _____

Patient/Guardian Signature: _____

Date to be completed: _____

Date patient will pick up: _____

Mail to/ Email to:

_____

_____