A.R. WYNNYKIW, DDS, PLLC
Progressive General & Cosmetic Dentistry

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ARWynnykiwDDS

DENTAL RECORDS TRANSFER RELEASE

I, _____, hereby authorize and direct
(Your Full Name)

_____

_____
(Name and Address of Dentist)

to release and forward all of my medical and dental records (including, but not limited to: medical history, dental history, treatment records/notes, treatment plans, and radiographs) to:

A.R. Wynnykiw, DDS, PLLC
351 Osborne Road
Loudonville, NY 12211

I have been informed of my rights under HIPPA by A.R. Wynnykiw, DDS, PLLC.

It is requested that these records be released promptly.

_____ _____
(Patient or Guardian signature) (Date)