

J. Craig Alexander D.M.D

739 Columbia Turnpike

P.O. Box 237

East Greenbush, New York 12061-0237

Telephone (518) 477-1008

DATE _____

PATIENT NAME (S) _____

I hereby request and release of transfer copies of dental treatment records and copies of x-rays on file at the office of **J. Craig Alexander, D.M.D.**, for the above named patients.

Please send these copies to:

Signature of person requesting transfer

Relationship to patient

DATE RECORDS TRANSFERRED _____