J. Craig Alexander, D.M.D., M.A.G.D.

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 _____

739 Columbia Turnpike • P.O.Box 237 • East Greenbush, NY 12061-0237
Phone: 518-477-1008 • Fax: 518-477-4399 • EMail: DrA@jcraigalexanderdmd.com • www.jcraigalexanderdmd.com