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

Date ____________________________

PATIENT NAME(S) ____

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I hereby request and release transfer of copies of dental treatment records and copies of x-rays on file at the office of

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for the above named patient(s).

Please email or send these copies to:

Email address:
Info@jcraigalexanderdmd.com

or

J. Craig Alexander, D.M.D.
739 Columbia Turnpike
P.O. Box 237
East Greenbush, NY 12061-0237

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Signature of person requesting transfer

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Relationship to patient

DATE RECORDS TRANSFERRED________________________________