CONSENT FROM PATIENT TO RELEASE DENTAL RECORDS

I hereby consent to the release of all dental records, including notes and radiographs, for   from the office of   to the office of:

Douglas A. Trolley, DDS/Trolley Dental Care
24 B Grove Street
Pittsford NY 14534
585-385-1315

Thank you,

Name: Date:

Signature of Patient or Legal Guardian