Pediatric Dentistry & Family Orthodontics

Andrew M. Arcuri, DDS, MS
Michael B. Quigley, DDS
Michael J. Weinstein, DDS
Young H. Son, DMD

8016 E. Genesee Street
Fayetteville, NY 13066

www.pediatricdent.com

Phone (315) 637-6961
Fax: (315) 637-0169

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(Doctor/Hospital)

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I hereby authorize the release of my dental records and request that they be transferred to:

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Phone: 315-637-6961
Fax: 315-637-0169

_____ DOB:_____
(Print Name of Patient)

_____ Date _____
Patients/Parents signature (Parent must sign if under age 18)