FRED P. TRIPODI, D.D.S., P.C.
Fred.TripodiDDS@gmail.com

530 Main Street
Armonk, NY 10504
(914) 273-4071
(914) 273-5041 (FAX)

694 Yonkers Avenue
Yonkers, NY 10704
(914) 965-3395
(914) 423-1457 (FAX)

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

DATE: _____

I, _____ **HEREBY GIVE PERMISSION FOR RELEASE OF MY / OUR DENTAL X-RAYS.**

COPIES FROM:

Dentist Name: Dr. _____

Address: _____

_____

PLEASE SEND COPIES TO (*check one*): ☐ **ARMONK** ☐ **YONKERS**
**contact information for each office in header.*

DIGITAL XRAYS TO: fred.tripodidds@gmail.com

Patient's Name: _____ _____

_____ _____

_____ _____

Address: _____

_____

Signature of Patient and/or parent or guardian: _____

PLEASE MAIL TO PREVIOUS DENTIST AT LEAST 5 BUSINESS DAYS BEFORE YOUR APPOINTMENT.

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. (Charges may apply for copies of records.)