RECORD RELEASE AUTHORIZATION FORM

I, ______________________________ hereby authorize Dr. James E. Maslowski, the keeper of my dental records from Dr. Richard Landry's office, to send these records to:

Drs. Mackler, Siurek and Assoc.
(Dentist Name)

46 Daggett Dr.
(Address)

W. Spfld, MA. 01089
(City, State, Zip Code)

Please checkmark below

- ☒ I understand that these records shall be provided within a reasonable amount of time not to exceed 30 calendar days from the date of the request.
- ☒ I am aware that I have received an invoice stating the fee to send these records.
- ☒ I also am aware that the dentist I have listed will now be the new keeper of my original records once they are sent and that Dr. James E. Maslowski will not be retaining any copies
- ○ List names of Minor Children whose records are being request.

____

____

____

X ______________________________
Signature

____
Street Address

____
City, State and Zip Code