Records Release Request

I, _____, hereby authorize _____ to release my dental records and x-rays to be transferred to:

Dr. Keith M. Sanger DDS

Sanger Dental at the Basin
661 Pittsford Victor Road
Pittsford, NY 14534
585-329-5000
Fax: 585-310-7535

Please send digital xrays to:
ksangerdental@gmail.com

□ I request digital xrays to be emailed

_____
Signature of Patient or Guardian