Records Release Authorization

I hereby request and authorize the release of my clinical records and radiographs concerning my past dental treatment at your office to:

Heather M. Billington, DMD
W. Daniel Billington, DMD
2911 Route 9
Ballston Spa, NY 12020
Phone: 518-580-8800
Email: hbillington@nycap.rr.com

Patient Name:_____**Date of Birth:**_____

Patient Name:_____**Date of Birth:**_____

Patient Name:_____**Date of Birth:**_____

Patient Name:_____**Date of Birth:**_____

Signature:_____

Date:_____

Previous Dentist:_____

Address:_____

Phone:_____