RECORDS RELEASE / REQUEST

TO: ____

ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP __________

I hereby authorize the release of my records and x-rays or copies of such and request that they are transferred to:

Dr. Philip N. Heinecke, DDS, PA

Dr. Ashley Heinecke Massey, DMD

Dr. J. Taylor Massey, DMD

7135 Mariner Blvd Spring Hill, FL 34609

Phone: (352)-796-0917 Fax: (352)-515-5761

Email: hmtooth@gmail.com

____

Print Name of Patient Date of Birth

____

Signature Date

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