Frederick R. Levine, D.D.S.
2142 Rosa Road ~ Schenectady, NY 12309
Phone (518) 370-0223 Fax (518) 370-3382
www.fredlevinedds.com

I, _____ hereby give permission and request the release of medical/dental records and/or x-rays for:

_____ X_____

Patient Name Signature/Date

PLEASE ENTER THE NAME, PHONE NUMBER & ADDRESS OF YOUR PREVIOUS DENTIST BELOW

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PATIENTS – PLEASE DO NOT WRITE BELOW THIS LINE

Dear Doctor & Staff: Please Provide

□ Date of Last Exam: _____

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□ Date of Last: Bitewings _____ **(Send Duplicate if < 12 months)**

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