1st Advantage
DENTAL

1662 Central Avenue • Albany, NY 12205
P: 518-452-2121 • F: 518-456-2865

Records Release Form

I, _____, hereby request 1st Advantage Dental, to release my records and radiographs as indicated below:

PATIENT NAME: _____
Patient Date of Birth: ____/____/____
Patient Address:

_____

_____

_____

Please release my records and radiographs to:

Name of Provider/Office:

_____

Address of Provider:

_____

_____

E-Mail Address of Provider: (Preferred for best quality)

_____

Reason for Transferring: _____

Signature: _____ Date: _____