Specialized Dentistry of New Jersey

James Courey, DDS & Joseph Zagami, DDS

732-577-0555

# REQUEST FOR RELEASE OF DENTAL RECORDS

Patient Name: _____ Birth Date ____/____/_____

I request and authorize _____*(office which records are requested from)* to release copies of all my dental records, including diagnostic x-rays and any other relevant information about services rendered to date, to the Prosthodontic Dental Office of:

**Specialized Dentistry of New Jersey**
**224 Taylors Mills Road**
**Suite 110**
**Manalapan, NJ 07762**
**Ph: 732-577-0555**
**Fax: 732-577-8555**
**Email: info@BuildingGreatSmiles.com**

***BY MY SIGNATURE BELOW I CONSENT TO THE RELEASE OF MY RECORDS AS DESCRIBED IN THIS AUTHORIZATION FORM.***

Patient Signature _____ Date _____

**James M. Courey, DDS**
Prosthodontic Specialty Permit #5245

**Joseph A. Zagami, DDS**
Prosthodontic Specialty Permit #6135