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:

Specialized Dentistry of New Jersey
224 Taylors Mills Road, Suite 110
Manalapan, NJ 07726
Ph: 732-577-0555
Fax: 732-577-8555
Email: xrays@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