RECORDS RELEASE

THOMAS M. PATREGNANI, D.D.S.
Cohoes Professional Center
55 Mohawk Street
Suite 206
Cohoes, NY 12047

www.cohoesfamilydentist.com

Date of Request_____

My permission is granted to Dr._____

To disclose to Dr. Patregnani complete information concerning the medical findings and treatment of

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Patient

From_____ To_____
Date Date

I release Dr._____
from any laws related to disclosure of confidential or privileged information.

Signature_____
Patient or Person Authorized to Consent for Patient

Address _____

Witness_____ Date_____

If possible....kindly send records via email to office@cohoesfamilydentist.com. Thank you!