



## Records Release/Request:

I hereby authorize the release of my dental records and my most recent dental x-rays. Please include a panoramic film if one was taken within the last 3 years. I request they be transferred to (Please circle one):

**Saratoga Springs  
Family Dentistry  
286 Church Street  
Saratoga Springs, NY 12866  
518.584.8150  
Fax 518.584.8751  
saratogafd.office@okrinse.com**

**South Glens Falls  
Family Dentistry  
63 Hudson Street  
Glens Falls, NY 12803  
518.792.2187  
Fax 518.792.2188  
sgf@okrinse.com**

**Gloversville  
Family Dentistry  
22 First Ave  
Gloversville, NY 12078  
518.725.1031  
Fax 518.773.4310  
gloversville@okrinse.com**

**Clifton Park  
Family Dentistry  
983 Route 146  
Clifton Park, NY 12065  
518.371.3333  
Fax 518.952.4331  
cliftonpark@okrinse.com**

**Greenwich  
Family Dentistry  
2651 State Route 40  
Greenwich, NY 12834  
518.692.9333  
Fax. 518.692.9696  
greenwich@okrinse.com**

**Queensbury  
Family Dentistry  
453 Dixon Rd Suite 5  
Queensbury, NY 12804  
518.792.1108  
Fax 518.798.4670  
queensbury@okrinse.com**

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Previous Dentist Information:

Dental Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_