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: _____