AUTHORIZATION FOR RECORDS RELEASE

TO:

_____

_____

I HEREBY AUTHORIZE AND DIRECT YOU TO RELEASE TO:

STEPHEN C. MALINCONICO, D.M.D.
770 Orange Street
New Haven, CT 06511

(203) 624-2280

The complete dental records in your possession

Name:_____

Address: _____

City_____State_____Zip_____

Signature: _____

Date: _____