RECORDS RELEASE/REQUEST

To

(Doctor/Hospital)

Address

City **State** **Zip**

Telephone

I hereby authorize the release of my

Records/ Xrays

Or copies of such, and request

they be transferred to :

William J. Fessler D.D.S.
116 East Avenue
Norwalk, CT 06855

Tel. 203.838.3939
Fax. 203.866.0406
admin@wfesslerdds.com

Patient Name

Patient Signature **Date**