

RECORDS RELEASE/REQUEST

To _____
(Doctor/Hospital)

Address _____

City _____ State _____ Zip _____

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 _____