MEDICAL RECORDS RELEASE FORM

I, _____, hereby authorize Drs. Kraski, Costello & Drake, PA to receive my dental records, including x-rays from:

_____

_____

_____

_____

My date of birth is _____. My Social Security number is _____.

Please send all of my information & x-rays to:

Drs. Kraski, Costello & Drake, PA
1089 W. Granada Blvd, Suite 1
Ormond Beach, FL 32174

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Wtness Date