**Joseph T. Schumer, DDS, LLC**
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The Smile Zone®

Request for Dental Records and X-Rays

Please complete form and mail to your previous Dentist.

Date: _____

To: _____
(Name of previous Dentist)

_____
(Address of previous Dentist)

_____
(City, State, Zip Code)

Dear Dr._____
(Name of previous Dentist)

I, _____, hereby authorize and request that you
(Name of patient) forward my dental records and X-rays to:

The Smile Zone
576 Sand Creek Road
Albany, New York 12205

_____
(Patient Signature)