Records Release Request

Date: _____

To: _____

_____

_____

I authorize the release of my dental records, including x-rays, to be transferred to:

Dr. Joseph Rava
Exton Dental Medicine Associates
305 N. Pottstown Pike, Ste 202
Exton, PA 19341
610-363-6870
Fax 610 594-6337

Signature: _____

Print Name: _____