RECORDS RELEASE / REQUEST

TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

I hereby authorize the release of my records and x-rays or copies of such and request that they are transferred to:

Heinecke Family Dentistry

Dr. Philip N. Heinecke, DDS, PA

Phone: (352)-796-0917

103 Bell Avenue Brooksville, FL 34601

Brooksville Fax: (352)-796-0937

Brooksville Email: Brooksville@drheinecke.com

7135 Mariner Blvd Spring Hill, FL 34609

Spring Hill Fax: (352)-515-5761

Spring Hill Email: hmtooth@gmail.com

Print Name of Patient Date of Birth

Signature Date