Dr. Thomas Sardina, D.M.D.
Sardina Dental Group
717-898-7221 405
Main Street
www.sardinadental.com Landisville, PA
17538

Authorization to Release Dental Records

Dr. Receiving request: ________________________________

Forward to: Dr. Thomas J. Sardina
405 Main Street
Landisville, Pa 17538
(717) 898-7221
(717) 898-7357 (fax)

If your computer system allows you to email x-rays, please send to:
sardinadental@gmail.com

I understand that this request and authorization applies to all dental care information, treatments done and current x-rays available.

I understand copies of the above information will be sent and that the original record will remain in the possession of Dr. Thomas J. Sardina.

A photocopy of this authorization is as binding as the original and is valid for a period of one year.

Name of Patient (s) ____

Social Security #(s) ____

Signature of patient(s) ____

Dr. Thomas Sardina, D.M.D.
Sardina Dental Group

717-898-7221 405 Main Street
www.sardinadental.com Landisville, PA 17538

Date signed ______________________