



Prosthodontics and Implant Prosthetics
Jeffrey B. Stannard, MS, DDS

Date: _____

RE: Transferring Records

You are hereby authorized to furnish and release all information, records, and radiographs for:

Patient: _____ Send To: Dr. Jeffrey B. Stannard, MS, DDS

Address: _____ Address: 1001 East Genesee Street

Syracuse, New York

Patient's Date of Birth: _____

I understand this information will not be disclosed to any other persons making inquiry with out written authorization by me. This authorization shall continue in force until revoked by me in writing.

Date _____ Patient Signature

Relationship to patient
if other than patient.

Witness _____