Records Release / Request

To: _____

Phone Number: _____ Fax Number: _____

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:

PALM HARBOR
FAMILY DENTISTRY

Dr. J. Taylor Massey, DMD, Dr. Ashley H. Massey, DMD

Dr. Kevin D. Kiley, DDS

3820 Tampa Road Suite #201

Palm Harbor, FL 34684

Phone: (727)-786-8302 Fax: (727)-781-4145

○ Dr. Massey's email: drmassey@smilepalmharbor.com

○ Dr. Kiley's email: drkiley@smilepalmharbor.com

Print Name of Patient Date of Birth

Signature Date