

**G. Kirk Gleason, D.D.S., P.C.  
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**To Our New Patients: Please fill out form below and forward it to your previous dentist.**

**RECORDS REQUEST AUTHORIZATION**

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I hereby authorize and request you to release current radiographs concerning my treatment or my child's/children treatment to:

**G. Kirk Gleason, D.D.S., P.C.  
981 Route 146 at George Drive  
Clifton Park, NY 12065**

Patient(s) Name(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_