ALLEN S RUANE DDS PC

1603 Rhawn Street
Philadelphia, PA 19111

215-333-1770
267-388-7012

I (we) _____request and authorize

_____

_____

_____

to provide and disclose treatment records and information concerning my dental care to Dr. Allen S Ruane DDS PC.

These records should include but are not limited to: patient information, medical and dental histories, treatment plans, treatment notes, radiographs, and any other related information. The treatment (progress) notes and radiographs are the most pertinent initially.

The sooner this information is received; I (we) will be able to proceed with my (our) dental needs. Please contact me or Dr. Ruane if you have any questions, need any more information, or have any problem regarding this request.

Thank you.

Patient _____ Date: _____

Address_____

_____

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