SUKONECK & WILSON, P.C.
BARRY F. SUKONECK, D.D.S., F.A.G.D.
RICHARD S. WILSON, JR., D.M.D., F.A.G.D

Date

I hereby authorize and request you to release the complete medical and dental records in your possession, concerning my treatment while under your care to:

Dr._____

Address_____

_____

_____

Email Address for Digital Images: _____

Signed_____ Date_____

Print Name _____

THE PHILADELPHIAN
2401 PENNSYLVANIA AVENUE, SUITE 1A8 PHILADELPHIA, PA 19130
PHONE: 215-765-5281 FAX: 215-765-7334