RECORDS TRANSFER REQUEST

Date:________________________

To: ____
(DOCTOR/HOSPITAL)

Address:____

City: ________________ State: ________________ Zip:________

I hereby authorize the release of my ________________________
or copies of such and request that they be transferred to:

A. Thomas Correia, D.D.S.
2441 Pawtucket Avenue — East Providence, R.I. 02914
(401) 438-4985

________________________ ________________________
(PRINT NAME OF PATIENT) SIGNATURE (PATIENT, PARENT OR GUARDIAN)