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**STEVEN G. BERWITZ**  
DMD

**Records Release Request**  
(If Applicable)

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

To: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I authorize the release of information related to my health history, status, and treatment, and copies of my health record, x-rays, and any test results (Protected Health Information) and request they be sent to Steven G. Berwitz, DMD.**

Print Name: \_\_\_\_\_

Sign Name: \_\_\_\_\_

**\*\*Please e-mail xrays to [info@stevenberwitzdmd.com](mailto:info@stevenberwitzdmd.com)  
in DEXIS or JPEG format.**