



Records Request Form

I give permission to _____

To release all information pertaining to _____

With date(s) of birth _____

Parent/Guardian Signature: _____

Parent/Guardian (Print): _____

Please send the requested information to:

Geneseo Orthodontics and Pediatric Dentistry

70 Main Street Geneseo, NY 14454

585-245-0050

Fax: 585-519-4226

Email: info@geneseosmiles.com