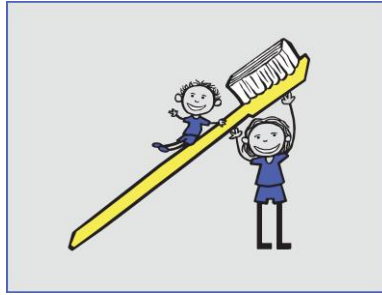


Alison M. Harding, D.D.S., M.S.

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Small to Tall Dentistry for Children, P.L.L.C

I _____ (parent/guardian),

request the records of _____ (patient name),

be released to: _____

(name, address & e-mail of dental office)

Relationship to patient(s) _____

Signature _____ Date _____

3171 Chili Ave., Suite 400
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Tel: (585)889-1290

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Tel: (585) 637-8125