HILLVIEW FAMILY DENTAL
6347 TRANSIT RD.
DEPEW, NY 14043
716 681-5468

DEAR DOCTOR:

I _____ REQUEST THE FOLLOWING INFORMATION TO BE FORWARDED TO:

HILLVIEW FAMILY DENTAL
6347 TRANSIT RD.
DEPEW, NY 14043

_____ DUPLICATION OF MOST RECENT X-RAYS

_____DUPLICATION OF WRITTEN RECORDS OF PREVIOUS WORK

THANK YOU FOR YOUR COOPERATION.

SINCERELY,