Request for Release of Dental Radiographs

Today's Date: _____

Your Name: _____ Date of Birth: _____

Present address: _____

I authorize: _____
(Name of previous dentist/office name) *(City & State)*

To release my dental radiographs via email as **jpeg files OR in DEXIS format** to:
sam@pittsfordfamilydental.com

Please list any dependent children under the age of 18
on behalf of whom you are making this request:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

_____
(Signature)

3592 Monroe Avenue Pittsford, New York 14534 | (585) 248-5250
pittsfordfamilydental.com | info@pittsfordfamilydental.com