PITTSFORD family DENTAL

Request for Release of Dental Radiographs

Today's Date_____

Patient's Name_____ Date of Birth _____

List any dependent children under the age of 18 years old.

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Address_____

City, State, Zip _____

Telephone Number_____

I authorize

_____

(Previous Dentist's Name)

_____

(Address)

_____

To release my dental radiographs to:

Pittsford Family Dental
3592 Monroe Avenue
Pittsford, NY 14534
(585) 248-5250

or e-mail digital films to:
desiree@pittsfordfamilydental.com

_____

(Patient signature)

****Please forward this directly to your previous dentist to expedite the transfer process. Thank you very much****