



**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 for whom you are requesting records.

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

\_\_\_\_\_  
(patient signature)