



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)