X-ray Release Form

Today's Date_____
Patient Name and DOB_____
Previous Dentist Phone# _____
Previous Dentist Fax #_____
Previous Dentist Name_____
Address_____

I, _____, am requesting the release of my dentals records and x-rays.

Please forward to the following address or email:
Dr. Justin Rivers
92 Crowell Road Chatham, MA 02633
Or
drjustinriversdds@gmail.com
Patient/Parent Signature_____
Print Name_____

Office use:
Last Prophy_____Last Exam_____
Last BTW's_____Last FMX/Pano_____