amherst dental group

RECORDS RELEASE/REQUEST

_____(DOCTOR/FACILITY)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby authorize the release of my x-rays or copies of such and request that they be transferred TO/FROM:

AMHERST DENTAL GROUP

smile@amherstdental.com

NAME OF PATIENT: _____(PLEASE PRINT)

DATE OF BIRTH: _____

DATE OF X-RAYS FROM: _____ TO: _____

PATIENT'S/GUARDIAN'S SIGNATURE: _____ DATE: _____

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