Calm Waters
DENTISTRY & IMPLANTS

PATIENT REQUEST FOR X-RAYS AND/OR RECORDS

To: _____

Attn: _____

Street Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

I hereby authorize the release of my x-rays and/or records or copies of such and request that they are transferred to Calm Waters Dentistry. Please email records and images to info@calmwatersdentistry.com.

_____

Patient's Name (Printed)

_____

Patient's Signature

_____

Patient's Date of Birth

_____

Date