Perfect Smiles dental care

8650 Candlelight Lane, Suite One, Lenexa, KS 66215
(913) 631-2677

Request for Radiograph(s) Release

I hereby authorize release of dental x-rays (radiographs) from Perfect Smiles Dental Care to:

Myself:

_____
Print Name

_____
Address

_____
City State Zip

_____
Email address

Or The Office Listed Below:

_____
Print Name of Office and/or Dentist Name

_____
Address of Office/Dentist

_____
City/State/Zip Office Phone Number

_____
Email Address Office Fax Number

****

_____
Print Patient's Name

_____
Signature of Patient/Guardian

_____
Patient's Date of Birth Patient's Phone Number

_____
Date of Request *Date of Scheduled Appointment with new dentist

***Kindly give at least 1 weeks notice for transfer of x-rays.**