CENTER FOR
ADVANCED DENTISTRY
We Make Anthem Smile

AUTHORIZATION TO RELEASE DENTAL X-RAYS TO ANOTHER HEALTH CARE PROVIDER

I, _____, am requesting a copy of my and/or my family's RADIOGRAPH(S). This request is for the necessity of continuity of care. This include(s) all radiographs of DIAGNOSTIC QUALITY. This request is to completed and sent within 15 (fifteen) business days to:

:

_____

_____

_____

_____

_____

_____

Or EMAIL:_____

_____ _____

(Signature of Patient/Head of Household/or Legal Guardian) (Date)