RELEASE OF DENTAL RADIOGRAPHS

I authorize: _____

(previous dentist)

_____

(address)

_____

(city, state, zip)

_____

(phone number)

to release my complete dental radiographs. As well as radiographs that were provided by any previous dentist to:

Moore Family Dentistry
1626 Harbor View Rd.
Charleston, SC 29412
843-795-4255
info@moorefamilydentistry.net

Patient's Name(s): _____

_____

_____

(signature)

_____

(date)