RECORDS RELEASE/REQUEST

(Dentist/Doctor Name)	
(Address)	
(Address)	
}	
I hereby authorize the release of my dental X-ra	ys/records to:
Bogdanfamilydentistry@gmail.com	<u>n</u>
or mail to	
Bogdan Family Dentistry	
3 School Street	
Bethel, CT 06801	
(Telephone 203-744-1646)	
Patient Name	
Signature of Patient	Date