Consent for Release of X-Rays

Please fill out the form below if you are coming to our office and would like for us to obtain x-ray records from a different office where you have been a patient. Please return the form to us via fax, mail, or e-mail prior to your appointment so that we may have time to obtain your records from your previous dentist before your appointment.

Patient Name _____ Date of Birth _____

Address _____ State _____ ZIP _____

Phone Number _____

I authorize and request a copy of my dental x-rays be released TO:

Ryan Dental Group
720 E. Main Street, Suite A
Allen, TX 75002
P 972.727.5001 F 214.644.0077
Office@RDGAllen.com

Records are to be released FROM:

Office Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____

Fax _____

E-Mail _____

Printed Name of Patient/Guardian _____

Signature of Patient/Guardian _____ Date _____