RECORDS RELEASE REQUEST

DATE:_______________

TO: ___________________________

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I,___________________________________ authorize the release of dental x-rays relevant to dental treatment, or copies of such, or myself and family members listed below, and request that they be transferred to:

If digital x-rays, please email to: fineartdentistry@hotmail.com

The Fine Art of Family Dentistry, PA
Lynn R. Wuthnow, DDS
1615 E Iron
Salina, KS 67401
785-823-5568

Family Members:________________________________

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Patient's Signature:____________________________________