BENDER FAMILY DENTISTRY

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Release of Records Consent

Please print the name of family member whose x-rays you would like transferred

Name: _____

Date of Birth: _____

Previous Dental Office: _____

___ I give Bender Family Dentisty permission to send my x-rays

___ I give my previous dental office permission to send my x-rays to Bender Family Dentistry

Patient/Legal Guardian Signature: _____

Today's Date:_____

Please send recent x-rays to: **benderfamilydentistry@hotmail.com**