Record / X-ray Release Form

Patient Name: _____

Address: _____

City, State & Zip: _____

I hereby authorize _____(name of dentist) to release my current dental x-rays to:

Drs Larson, Martyn & Hafner, DDS
10562 N Port Washington Rd
Mequon, WI 53092
Phone (262)240-1220
Email Address: lmhdental@gmail.com

I understand that my actual dental records, by law, belong to the dentist. I understand that the information contained in the record belong to me. I agree to accept copies or duplicates of such records and x-rays.

_____ _____
Signature Date

Additional family members: _____

_____

_____

Previous Dentist Address: _____

_____

Phone: _____

OFFICE USE	Date	Initials
o Called Office (prev Doctor)	_____	_____
o Faxed request	_____	_____
o Received information	_____	_____
Circle that which applies:	digital or film	

1.21.14 REVISED -jb