Consent for Release of Radiographs

Please fill out the form below if you are coming to our office and would like us to obtain xray records from a different office where you have been a patient. Please return the form to us via fax, mail, email or provide this form to the office you are requesting your records from so that we may have time to obtain your records from your previous dentist prior to your next appointment.

Patient Name: Date of Birth:

Address: State:

Zip:

Phone Number:

I authorize and request a copy of my dental radiographs be released to:

Robert J Freitas II, DDS
Freitas Family Dentistry
1145 Second Street, Ste G
Brentwood, CA 94513
Phone: (925) 634-1230
Fax: (925) 513-8760
Email: drfreitas@freitasdentistry.com

Records are to be released from:

Office or Doctor's name:

Address:

City: **State:** **Zip:**

Phone: **Email:**

If patient is a minor printed name of Guardian:

Patient or Guardian's signature [[FIRST]] [[LAST]] Date: