Patient Consent Form
Request to Release Dental Records

Patient Name: ________________________________ Date of Birth:____________

Previous Name: ________________________________

I have requested and authorize the release of a copy of the dental records

including radiographs, for the patient named above to be sent from the office of:

Dr. ____

____
Address

__________________________________ __________ ________________
City State Zip

__________________________________ ______________________________
Phone Fax

To the office of: **Dr. William S. Demray, 371 E. Main St., Northville MI 48167**

____ ______________________
Signature of Patient or Patient's Legal Representative Date

____ ______________________
Print name of Patient or Patient's Legal Representative Relationship to Patient

In an effort to best treat our mutual patient please note:

Do not send films, digital or otherwise, that are not accurately labeled.

If you are providing x-rays to the office of Dr. William S. Demray please indicate the patient's name, practice name, a contact person with a phone number or email address; include the date the x-ray(s) was/were taken and indicate R (right) or L (left).

If sending analog radiographs do not copy in mounts. Thank you.