

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT NAME: _____ **D.O.B:** _____

ADDITIONAL FAMILY MEMBERS/D.O.B: _____

I authorize _____ to release my dental x-rays
to the office listed below: **(Please Dentist, phone # or E-mail.)**

SHORTT DENTISTRY

720 W. HOUGHTON AVE

WEST BRANCH, MI 48661

P-(989)345-0185

EMAIL: infowb@shorttdental.com

Please forward any current x-rays! Thank you!

BITEWINGS: _____

PANO/FMX: _____

Patient(s)/Guardian Signature

Date