

BY THE LAKE DENTAL PATIENT CHART RADIOGRAPH RELEASE REQUEST

Dear Dr. _____

Fax #: _____

Phone #: _____

Kindly forward my Patient Chart and/or dental radiographs and those of any of my family members, requested here, to the office listed below.

| Chart | X-ray |
|-------|-------|
| | |
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| | |
| | |

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Send to: _____

Thank you.

**Name of Patient, Parent or
Guardian**

**Signature of Patient, Parent or
Guardian**

Date