Mendota Dental Associates

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RELEASE OF RECORDS

Please send x-rays TO MENDOTA DENTAL for the following patients:

1. _____ Date of Birth:_____
2. _____ Date of Birth:_____
3. _____ Date of Birth:_____
4. _____ Date of Birth:_____
5. _____ Date of Birth:_____
6. _____ Date of Birth:_____

√ **Signature:**_____ **Date:**_____

PRINT THE NAME of the person requesting:_____

Previous Clinic Name: _____

Previous Dentist Name:_____

Address: _____

Phone:_____ **Fax:**_____

Email: _____

*(THIS IS THE PREFERRED METHOD AND **MUST** BE PROVIDED BY YOU. **PLEASE CALL THEM IF IT'S NOT READILY AVAILABLE ON THEIR WEBSITE).*

OFFICE USE ONLY: FMX:_____ Pano: _____ BWX: _____

❑ Sent form via _____ By_____ Date_____ Time_____

❑ Received x-rays via _____ By_____ Date_____ Time_____