Bridgeworks Family Dental Center
115 Bridge Street
Groton, CT 06340
860-446-8744

REQUEST FOR RELEASE OF X-RAYS

I, _____, authorize the release of my dental x-rays from

_____

phone# _____ fax#_____

Please release to :

_____

_____

_____

Signature:_____
(Patient or persons authorized to consent for patient)

Date:_____