Malcomson
DENTISTRY

Radiograph and Records Release Request

To:_____ (Previous Dentist)

Address: _____ State: _____ Zip: _____

Email: _____@_____.com Phone: (____)_____ FAX: (____)_____

I authorize the release of my dental radiographs, along with a copy of my dental records to:

Malcomson Dentistry
E. Denise Malcomson, D.D.S.
8218 Wisconsin Avenue, Suite 415
Bethesda, MD 20814
Office: (301) 656-1588
Email: MalcomsonDentistry@gmail.com
www.MalcomsonDentistry.com

Last set of Bitewings (BWX) Date: _____

Last Full Mouth Series (FMX) Date: _____

Panoramic radiograph (PANO) Date: _____

Periapical xrays (PAs) Date: _____

_____ _____ _____

PRINT Patient Name | Patient or Guardian's Signature | Date

- Please cancel any scheduled appointments.

~CONFIDENTIAL~