Date:_____

DANIEL J. PASSIDOMO D.M.D
Cosmetic & Family Dentistry

RELEASE OF RECORDS REQUEST:

Previous Dental Office:

_____

_____

_____

_____

Phone #:_____

Fax #:_____

Email:_____

I, _____ Date of Birth:_____
(Print Full Name)

Hereby authorize you to release my / my family's most current x-rays. This includes a Full Mouth Series / Panoramic x-ray within the last 5 years or Bitewing x-rays within the last year.

Please send to:

Dr. Daniel J. Passidomo D.M.D.
9989 Dayton Lebanon Pike
Centerville, OH 45458
(937) 886-9935
(937) 886-9937
info@dpsmilecenter.com (PREFERRED)

Signature:_____

If requesting the release for family members, please print names and birth dates below:

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____