Drs. Neighbors, Herod & Moretti

P.O. Box 158

Midlothian, VA 23113

info@midlodental.com

X-RAY REQUEST FORM

This is to authorize: ____

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To release any information concerning:

Patient Name: ____

Date of Birth: ____

Address: ____

Phone: ____

Please send digital records to info@midlodental.com

Please transfer records prior to: ____

PATIENT/GUARDIAN SIGNATURE

____

RELATIONSHIP IF OTHER THAN PATIENT **DATE**

______________________________________ ________________________