Masha Kogan, DDS

DENTAL X-RAYS REQUEST FORM

Dear Dr. _____ in _____
(Previous Dentist's Name) (City, State)

I, the responsible party listed below, hereby authorize and request the release of digital X-rays to the Dental Center of Westport via e-mail to:

care@dentalcenterwestport.com

I acknowledge that my private dental X-rays will be transmitted over the Internet.

_____ _____
Patient/Guardian Name (Print) Signature

_____ _____
Date Date of Birth

250 Main Street • Westport, CT 06880 • 203-227-8700 • care@dentalcenterwestport.com
www.dentalcenterwestport.com