Radiograph Request Form

Patient Name: _____DOB: _____

Street Address: _____

City/State/Zip: _____

Phone #: _____

E-MAIL: _____

I hereby authorize the release of my radiographs and/or dental records or copy of such and request that they be transferred TO:

WESTON DENTAL SPECIALISTS GROUP, PC
56 COLPITTS ROAD
WESTON, MA 02493
T. 781-894-0347
F. 781-894-0835
E-MAIL: doc@westonprostho.com

Please notify me of any additional necessary steps or fees involved with having records sent.

Patient Signature: **Date:**