X-Ray & Records Release Form

I authorize _____ to release my dental records to Ortisi and Abate Family Dentistry and make copies of my X-rays as needed.

I understand that I may be charged a fee for such services.

Please forward my records to the following address:

Ortisi and Abate Family Dentistry
13801 15 Mile Rd.
Sterling Heights, MI 48312

Patient Name/Responsible Party: _____
Signature: _____