Galleria Dentistry

CONSENT TO RELEASE DENTAL RECORDS

I, _____hereby give my consent

(Patient Name)

To _____ for release of my dental x-rays to:

GALLERIA DENTISTRY

9140 GALLERIA COURT

NAPLES, FL 34109

For digital x-rays, please email to: INFO@GALLERIADENTISTRY.COM

_____ _____

Patient Signature Date