Records Release/Request

I hereby authorize Long Wharf Dental Group to:

☐ request copies of necessary x-rays from:

Office: _____

Address: _____

Phone: _____ **Fax:** _____

E-mail: _____

Please send x-rays to LongWharfOfc@DentalCareAlliance.com in DEXIS format, if possible

☐ release copies of necessary x-rays to:

Office: _____

Address: _____

Phone: _____ **Fax:** _____

E-mail: _____

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Long Wharf Dental Group

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Suite #221

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