THE HILL DENTAL GROUP, PLLC

8338 SPRING CYPRESS ROAD

SPRING, TX 77379

281-376-0911

info@hilldentalgroup.com

RELEASE OF RECORDS

Patient's Name (Print) ________________________________DOB____________

________________________________DOB____________

________________________________DOB____________

________________________________DOB____________

_____ I request xrays to be sent from:

Office Name: ____________________________________

Email: ____________________________________

Phone Number: ____________________________________

_____ I request xrays to be sent to:

Office Name: ____________________________________

Email: ____________________________________

Phone Number: ____________________________________

Signature:____________________________________ Date: _______________

Relationship to Patient(s) ____________________________________