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RELEASE AUTHORIZATION FOR DENTAL X-RAYS AND RECORDS

Dr. Gail G. Goodman and Dr. Gerald L. Diquattro extend a professional courtesy by mailing or emailing duplicate x-rays and records, *free of charge*, to the dentist of your choice.

Patient name: _____
Date of Birth: _____
Address: _____
City/ State: _____
Zip Code: _____
Daytime phone: _____

I, _____, hereby request and authorize you to release the x-rays
Print Name

and records for _____ from Dr. Goodman & Dr. Diquattro to:
Patient's Name(s)

Dentist name: _____
Address: _____
City/ State: _____
Zip Code: _____

Signed: _____ (_____)
Relationship to patient(s)

Date: _____



Reason for record transfer:

Insurance Coverage: _____ Other (please specify): _____

Moving: _____