Dr. Farhad Foroughi D.M.D. Dr. Dora E. Jarquin D.M.D.

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Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the office of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release all current dental x-rays to the office of Family Smile Dentistry.

If they happen to be digital, please email to **frontdesk@familysmiledentistry.com**

I understand that my records will no longer be the responsibility of your office and I will now be a patient of Family Smile Dentistry. I appreciate your cooperation in the forwarding my information in a timely manner.

Patient Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_