Joseph M. Pope D.D.S., LTD
4410 North Knoxville Avenue
Suite C
Peoria, Illinois 61614
309.688.7007

X-Ray and Dental Records Release Form

Date: _____-_____-_____

Dr. _____
{Dentist You Are Requesting X-rays and Dental Records From}

I hereby authorize you to release all dental radiographs and/or dental records for

_____.
{Patient's First and Last Name}

Please forward all materials to:

Joseph M. Pope D.D.S., LTD.
ATTN: Heather Williams
4410 North Knoxville Avenue
Suite C
Peoria, Illinois 61614

Signature: _____
{Patient or Legal Guardian }