North Bethesda Periodontal Group

X-Ray and Records Release Form

I, ____:
(Please print)

Authorize the release of my dental records, including copies of radiographs, treatment records and medical history to be sent to:

North Bethesda Periodontal Group
11921 Rockville Pike, Suite #407
Rockville, MD 20852

If you are able to provide digital x-rays please e-mail documents to:
Contact@NorthBethesdaPerio.com

____
(Patient signature or Legal Guardian signature)

Date: _____ / _____ / _____

11921 Rockville Pike
Suite 407
Rockville, MD 20852
T: 240-483-0775
F: 240-238-8626
www.northbethesdaperio.com