



Richard J. Garcia, DMD

AESTHETIC DENTISTRY

PATIENT X-RAY AND/OR RECORDS REQUEST FORM

Name of Dentist: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone #:(_____) _____ Email #: _____

I, the undersigned, hereby request and authorize the release of my dental records including x-rays, diagnosis and treatment (past, present or future) to be released to:

E-Mail or Mail to:

E-mail: frontdesk@SmilesOfNaples.com

Dr. Richard J. Garcia
7385 Radio Road, Suite 103
Naples, FL 34104

Patient Name: _____

(Print Name)

Patient Signature: _____ **Date:** _____

(Patient or Guardian)