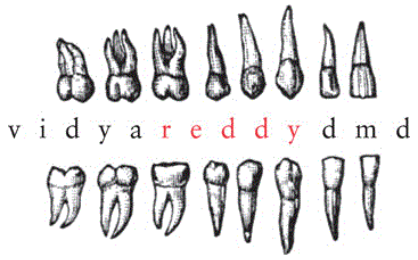

Vidya Reddy DMD
290 Baker Avenue Ext Suite N224
Concord, MA 01742
(978)369-3831
Fax (978) 369-0679

To the Dental office of:

Name:
Address:

Office telephone:
Office Email: _____

Dental Radiograph/History Release

I, _____, authorize the release of my recent complete series of radiographs and/or panoramic radiographs (up to 5 years prior) and bitewing radiographs (up to 18 months prior) plus a copy of my dental history from your office to the office of Vidya Reddy DMD. This office accepts all digital radiographs by email to:

office@vreddydmd.com

Thank you for your assistance in forwarding these records.

_____ _____
Signature of Patient or Guardian (if minor child) Date