ST JOHNSBURY DENTAL ASSOCIATES
ONE PLACE NOTRE DAME
ST. JOHNSBURY, VT 05819
802-748-9357

REQUEST FOR RELEASE OF
RADIOGRAPHS AND DENTAL RECORDS

PLEASE: NO PAPER COPIES OF FILMS

TO:_____

_____

_____

MAIL TO: **ST JOHNSBURY DENTAL ASSOCIATES**
ONE PLACE NOTRE DAME
ST. JOHNSBURY, VT 05819

PATIENT Name:_____
(printed)
DATE OF BIRTH:_____

PATIENT (or Parent/Guardian Signature):_____
DATE: _____