Date: _____

I authorize the release of my dental records, including bitewings within the past year and FMX or panoramic films within the past 5 years to:

Curtis E. Hahn, DDS
Rivertown Dental Associates
4992 Wilson Ave. SW
Grandville, MI 49418
info@rivertowndental.com

Thank you.

_____ _____
Signature of Patient Date

_____

Patient Name(s)