River City Dentistry
39 West Williamsburg Road
Sandston, Va. 23150
Main: (804) 737.7402
Fax: (804) 737.5442
rcdeast@rivercitydentistryrva.com

PATIENT CONSENT FORM
RELEASE RECORDS AND RADIOGRAPHS

I hereby request, and consent to, the release of my records and radiographs to the office of: River City Dentistry

Patient's Name: _____

Address: _____

Phone #: _____

From the office of: _____

Address: _____

Phone #: _____ **Fax #:** _____

Email: _____

Thank you,

_____
Printed name of patient

_____
Signature of patient or legal guardian

_____
Date