



Dental Records Request

To Whom It May Concern:

Name (Last,First): _____ Birthday: _____

The patient above requests and/or authorizes the release of their radiographs to McKee Dental. It is only necessary to send:

1. Bitewing radiographs if less than one (1) year old.
2. Full mouth series or Panoramic if less than five (5) years old.

Please forward diagnostic film copies by mail to the address on the bottom of the page.

For digital radiographs, **paper copies and/or faxes of copies are not diagnostic**. Please send proper digital records if you no longer use film.

Digital copies can be emailed to: Xrays@McKeeDental.com
Alternately, they may be burned to a CD-Rom and sent by mail.

I, _____, hereby request that copies of my radiographs along with any pertinent treatment records be forwarded to McKee Dental.

Signature: _____ Date: _____

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