TriState Family Dental Centers

A Professional Corporation

Established in 1971

Request for X-Ray Release

Dear Doctor,

I hereby authorize copies of my x-rays be released to TriState Family Dental Centers at xrays@tristatefamilydental.com or mail to the address below:

(Patient should circle address before submitting request to current dentist.)

960 S. Hebron Ave. Evansville, IN 47714 (Eastside)	800 First Ave. Evansville, IN 47710 (Northside)

Signed: ____ Date: ________________________

Note to Patients: Please allow reasonable processing time which is typically 5-7 business days from receipt of this authorization.

Please fill out the following information for identification purposes.

Please print.

Patient Name: ____

Address: ____

Phone #: ____

Date of Birth: ____