Alexiou Dental Arts

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(330) 688-0067 • (330) 688-0277 (Fax)
alexioudentalarts.com

At my request, I _____ have given Alexiou Dental Arts permission to release the following patients x-rays and/or records to my present dentist.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

New Dentist Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____