



CHRIS FURLAN, D.M.D.
51 West Eagle Road
Havertown, PA 19083
Phone: 610-789 – 4414 Fax: 610-789-4420

TO: _____

RE: _____

DATE: _____

Dear Doctor:

The above named patient recently presented to my office for dental treatment. We have advised the patient that previously taken radiographs and treatment records are an important part of the information we will need to deliver comprehensive care.

Would you be so kind as to forward to our office:

- **bitewing and single periapical films taken in the last five years.**
- **full mouth and panoramic radiographs taken in the last ten years.**
- **all treatment records of significance to future care.**

Please note that if you have digital radiographs, you may forward them as e-mail attachments (.jpg or Dexis format) to havertowndentists@verizon.net

Thank you in advance for your help and prompt attention to this request. Please contact me if there is any additional information you may need.

Sincerely,

Patient Release:

I authorize the release of my above indicated dental records and radiographs to DR. Furlan.

Signature: _____ Date: _____

Social Security #: _____ Date of birth: _____