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**Allied Dental Education Department**

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Email Address: NHTIDentalClinic@ccsnh.edu

**CLIENT REQUEST TO RELEASE RADIOGRAPHS**

The radiographs of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_are to be

 (Please check one of the following)

 Sent to Dr. Address: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Emailed Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Given to client on: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mailed to client’s Address: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client’s Signature Date

6/21/2010