Date:

I, ____________________, authorize the release of my dental radiographs to William Bissell, DDS via email at info@bisselldentalgroup.com If you are not digitally capable, please mail them to:

William Bissell, DDS
1660 S. Albion St. #607
Denver, CO 80222
303-757-6139

I also authorize you to release any information pertaining to my dental treatment to Dr. Bissell and his staff including, but not limited to, the date and type of radiographs that were taken at your office. Please contact me should you have any questions.

Thank You,

____
(Patient's Signature)