GENERAL DENTAL RELEASE

I, _____, hereby authorize
Print Name

Dentist: _____

Address: _____

_____

Phone Number: _____

to release copies of my x-rays and records to Turkey Creek Dental, Dr. James R. Williams' office. You may send my information to the following address:

Turkey Creek Dental

10641 Deerbrook Dr.

Knoxville, TN 37922

Ph: 865-675-3685

Fax: 865-671-1239

e-mail: turkeycreekdental@tds.net (they do accept digital x-rays)

Patient Signature: _____

Date: _____