

**Radiograph Request**

To: \_\_\_\_\_ (Dentist's Name &  
Address)

\_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_, hereby authorize you to  
Patient's Name  
release my radiographs to the below named dental practice:

**The Center for Aesthetic & Restorative Dentistry  
Steven C. Bunting, D.D.S  
3443 Huntingdon Pike  
Huntingdon Valley, PA 19006  
(215) 947-4111**

Thank you for your prompt attention to this matter.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_