

# Peter A. Timian, DMD

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## X-RAY TRANSFER REQUEST

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

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: [\_\_\_\_\_] \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

I authorize the release and transfer of dental x-rays.  
Please forward to:

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

\*\*\* *IF minor child:* Name of Parent authorizing  
release/transfer: \_\_\_\_\_

**X**  
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date