Ralph Sahakian, D.M.D.
14 Lake Avenue
Worcester, Ma 01604
508-755-1097

Date: _____

Patient Name: _____ Date of Birth: _____
(Please Print)

I hereby authorize the release of my x-rays/records to:

_____ Myself

_____ Dr. Ralph Sahakian
14 Lake Avenue
Worcester, MA 01604
FDSAHAKIAN@GMAIL.COM

_____ Dr. _____

_____

_____

Patient Signature: _____

Fax to: _____ Fax #: _____