

Gregory S. Brya, DDS, PLLC

drbrya.com

4780 Okemos Road | Suite #1 • Okemos, MI 48864

drbrya@drbrya.com

(517)381-8181

Record Release / Access Form: To Our Office

Patient Name: _____
Last First MI Preferred Name

Date of Birth: * _____

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Records to Release/Access: *

FMX or Bitewing Treatment Information

I authorize the release of dental radiographs and treatment records to:

Gregory S. Brya, DDS, PLLC
4780 Okemos Road, #1
Okemos, MI 48864
Please email to: drbrya@drbrya.com

Thank you for your prompt attention.

Patient Information:

Name: *

Signature of patient, parent or guardian (responsible party):

Signature _____ Date _____

Relationship to Patient: *

Spouse Child Parent Guardian Other

Date: * _____

Response Date: _____