X-Ray Release Form

Please forward my/our xrays to: Dr_____ Phone #:_____

Fax #_____ Email:_____

I, _____, authorize you to release my dental records/radiographs. In addition to myself, please include the following members of my family:

_____
_____
_____

Reason for transfer:

_____ New Dentist
_____ Referral to specialist
_____ Second opinion

I release you from all legal responsibility that may arise from this and confirm that my account is at a zero balance.

Signed (Patient or Guardian) _____Date:_____