RELEASE FORM OF DENTAL X-RAYS

I, _____, with the date of birth

of: _____, do hereby give permission to send my dental x-rays to the provider of my choice.

Signature of patient *or*
parent/guardian:_____

Date:_____

Please send to:

Provider name: _____

Street Address: _____

City, State, Zip code: _____

E-mail address: _____