

## X-Ray Release For

I, \_\_\_\_\_, give authorization for  
Dr. \_\_\_\_\_ office to release my dental  
x-rays for my continued treatment to:

Dr. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name-Print

\_\_\_\_\_  
Patient Name- Sign