

AUTHORIZATION TO RELEASE X-RAYS/RECORDS

I, _____, (patient), hereby authorize and request my dentist, Dr. _____, to release copies of my dental x-rays for (circle one) *self only* or *family*, to be sent to:

NAME: _____

ADDRESS: _____

TELEPHONE: () _____

OR release said records to be picked up by:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

Signed this the _____ day of _____, 2004.

SIGNATURE OF PATIENT

SIGNATURE OF PARENT/GUARDIAN IF THE
PATIENT IS A MINOR

***PLEASE MAIL OR DROP THIS FORM BY THE DENTIST OFFICE AT:
100 Heatherbrooke Drive, Suite A
Birmingham, Alabama 35242***