Dental patient X-rays release form

Date: _____

Dentist requesting X-rays: _____

Dental Clinic: _____

Phone #: _____

E-mail: _____

Patient Name: _____

DOB: _____

Phone #: _____

I, _____, **give my permission** to Dr.Andriy Yegorovykh (Pure North Dental Clinic) to transfer copies of the patient's X-rays to the above named dentist for the purpose of allowing to diagnose and plan treatment.

Patient's signature _____

Guardian signature _____

Guardian relationship/authority _____

We will requre a power of attorney proof if requesting for other than your minor child.