X-Ray Release Form

Date: _____

Dr: _____
{Dentist you are requesting x-rays from}

I hereby authorize release of any current dental radiographs and/or charting for

_____.
{patient first and last name}

Please forward x-rays to:

Timm Family Dentistry
375 NE Emerson
Bend, OR 97701
541-382-1991
541-330-9095 fax
Or send via email to: info@timmfamilydentistry.com

Signature: _____
{patient signature}