I, _____herby authorize and request the release of x-rays taken of me to:

(Please Print)

☐ **Me (The Patient)**

ADDRESS:

_____

CITY/STATE/ZIP_____ Phone:

_____

☐

Dentist/Dental Office

ADDRESS:_____

_____

CITY/STATE/ZIP _____
Phone:_____

I understand that these X-rays are part of the original dental records which belong to Carolina Dental Care. I also understand that a processing fee of $25 will be charged to obtain copies of all dental records and x-rays.

Patient's
Signature_____

Date: _____

Released By:

_____

Date of Release: _____