

Carolina Dental Care



X-Ray Release Form

I, _____ hereby 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: _____