funke
family dentistry

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X-Ray Release Form

I, _____ authorize and request the release of x-rays taken of me to:
(Please Print Name)

☐ Me (The Patient)

Email: _____

Address: _____

City / State / Zip: _____ Phone: _____

☐ Dentist / Dental Office

Email: _____

Address: _____

City / State / Zip: _____ Phone: _____

I understand that these X-rays are part of the original dental records which belong to Funke Family Dentistry.

Patient's Signature_____

Date: _____

Released By: _____

Date of Release: _____