A TO Z PEDIATRIC DENTISTRY

X-RAY RELEASE FORM

Patient's Name: _____

As parent or legal guardian, I do hereby give consent to A to Z Pediatric Dentistry to release a copy of my child's x-rays to:

_____

_____

_____

For purposes of:

_____

_____.

_____ _____

Parent or Legal Guardian Signature Date

_____ _____

Witness Signature Date