BAUMWOLL ORTHODONTICS

🦷 **Dental X-Ray Release Form**

Patient Name: _____
Date of Birth: _____

I give permission to release my dental x-rays to:

Receiving Office/Doctor: _____
Phone or Email: _____

X-Rays to Release:
☐ Full Mouth
☐ Bitewings
☐ Panoramic
☐ Other: _____

How to Send:
☐ Email
☐ Printed Copy
☐ Other: _____

Patient Signature: _____
Date: _____

If patient is under 18 years of age:

Parent/Guardian Name: _____
Relationship to Patient: _____
Parent/Guardian Signature: _____
Date: _____