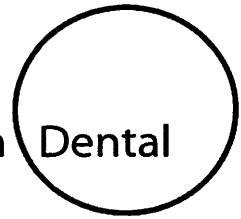


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## **X-Rays and/or Dental Records Release Form**

Patient Name: \_\_\_\_\_

Requested By (if other than the patient): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Exam Date(s) Requested: \_\_\_\_\_

X-Rays to be sent to/e-mailed to:

\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, authorize the release of the X-ray(s) and/or dental records requested above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_