Thomas Yoon Dental

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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: _____