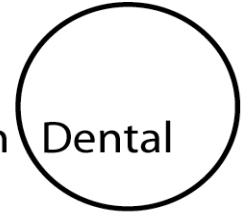


Thomas Yoon Dental



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

Patient Name (Last, First): \_\_\_\_\_ Date of Birth(mm/dd/yyyy): \_\_\_\_\_

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

Date(s) Requested: \_\_\_\_\_ (as needed) \_\_\_\_\_

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

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

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

\_\_\_\_\_  
Patient/Legal Guardian Name Printed

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date