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