Lake Superior Dental associates

RELEASE FORM FOR DENTAL X-RAYS

I, _____DOB:_____ do hereby give permission to
(Patient Name) (Date of Birth)

Lake Superior Dental Associates to copy my dental x-rays and send them to the provider of my choice.

_____ _____
(Signature of patient *or* parent/guardian) (Date)

Please send to:

Provider name: _____

Street Address: _____

City, State, Zip code: _____

Email of Provider (if you wish us to email x-rays):_____