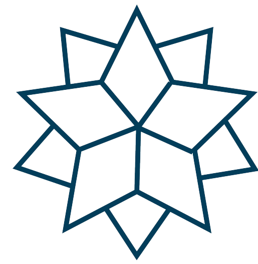

X-RAY RELEASE FORM

DATE: ___________________________

DR.: _____________________________ Address: ____
(Dentist you are requiring x-rays from)

Phone: ______________________________ Fax: ____
(Print Patient Name)

I hereby authorize you to release all dental radiographs for ____

Names of Children (under age 18):
____

Please forward x-rays to:

Dr. Steven L. Jabs
Jabs Family Dentistry
201 S. Meridian Street
Belle Plaine, MN 56011
office@jabsdentistry.com
952-873-6766 Phone
952-873-5489 Fax

SIGNATURE: _______________________________________
(Patient Signature)