Sterling Family Dentistry, P.C
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586-323-CARE (2273)

X-RAY RELEASE FORM

To:_____________________________ Date:___________

Address:_________________________

City:____________________________ State:______ Zip:____________

I authorize the release of my dental X-rays, or copies of such to the address below:

Please mail this form with your payment for the X-ray duplication fee to our office. We can not send your copies until both are returned to us.

Thank You.

____________________________ ____________________________
Print name of patient Signature of patient, parent or guardian