



X-RAY RELEASE FORM

Phone: (941) 907- 8300 or Fax:(941) 907- 8206

To:	From: Lakewood Ranch Dental
Fax:	Pages: 1
Phone:	Date:
Re:	CC:
<input type="checkbox"/> Urgent <input type="checkbox"/> For Review <input type="checkbox"/> Please Comment <input type="checkbox"/> Please Reply <input type="checkbox"/> D'YUgY'FYVWVW	

Please send x-rays as attachments in *Dexis* or *jpeg* format and include exact date films were taken. Thanks :)

To whom it may concern,

I, _____, hereby grant permission for _____ 's office to release any information related to my dental history and treatment, along with copies of my x-rays to:

Email: Smile@lakewoodranchdental.com
If possible we prefer x-rays by email over regular mail.

Lakewood Ranch Dental
6270 Lake Osprey Drive
Sarasota, FL 34240

Signature: _____

Date: _____

Thank you for your attention in this matter.