Allen Family Dentistry, LLC

X- Ray Release Form

I authorize the release of my x-rays to Allen Family Dentistry, LLC in Mount Pleasant, SC.

Patient Name_____ DOB _____

To:

Allen Family Dentistry, LLC

2675 Brickside Lane, Suite 100

Mt. Pleasant, SC 29466

Phone: 843-216-7488

Fax: 843-216-7489

Please send via email if you have digital x-rays to: frontdesk@allenfamilydmd.com

_____ _____

Signature of Patient or Guardian Print full name

Date: _____ Phone: _____

Authorization expires on _____ (Not to exceed 90 days)