Valley View Dental Care

X-Ray Release Form

I _____, DOB:_____ hereby authorize and request the
(print name)

release of x-rays taken of me by Valley View Dental Care to:

□ Me (patient)

□ Dental Office:
Practice Name:_____ Dentist:_____
Address: _____
Email:_____
Phone: _____ Fax: _____

□ Other:
Name:_____ Relation:_____
Address: _____
Email:_____
Phone: _____ Fax: _____

Signature:_____ Date: _____