

# TP Dentistry



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## **AUTHORIZATION TO RELEASE RADIOGRAPHS**

I HEREBY AUTHORIZE THOMAS PHAM DENTAL TO RELEASE X-RAYS FOR ....

Patient \_\_\_\_\_ DOB \_\_\_\_\_

Other Family Members to transfer: \_\_\_\_\_

Release radiographs to: Dr. \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Fax#: \_\_\_\_\_

Email: \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_

Patient/Parent or Guardian