DAMERON FAMILY
DENTISTRY

3156 East Cherokee Drive
Canton, GA 30115

770-345-8646(phone) 770-345-5540(fax)

X-ray Release Form

I, _____, give authorization for the office of _____ to release my dental x-rays to the office of: Dameron Family Dentistry for my continued treatment.

_____ _____

Date Patient Name (Print)

_____

Patient Signature (Parent if Minor)

Please forward requested x-rays (in a .jpg format) to Dameron Family Dentistry to our email address: xrays@dameronsmiles.com. If x-rays are not digital, please send to above address.