grover
DENTAL CARE
Smiles "R" uss

RADIOGRAPH RELEASE FORM

Date: _____

Patient Name: _____

I, _____, authorize Dr. _____ to release Radiographs and/ or records to Grover Dental Care as I am now a patient of their practice.

The Radiographs are for: ☐ Myself

☐ My children _____

_____

_____

Thank you for your prompt attention to this request.

Signature of Patient _____