

Radiograph Release Form

Patient Name: _____

Date: _____

I hereby state that I have requested the release of the medical radiographs and/or other records of _____ which are currently the part of the patient record files held by Kids Healthy Teeth. I acknowledge the release of the aforementioned records and associated documents to _____, and I fully discharge Dr. Elizabeth Chen, Dr. Sheryl Hunter-Griffith, and Kids Healthy Teeth from any liability that may arise as a consequence of their release.

Signature: _____

Printed Name: _____

Witnessed By: _____

Printed Name: _____