X-RAY Release Request Form

Date: _____

Patients Name: _____

Additional Family Members: _____

_____

Address: _____

_____

Date of Birth(s): _____

_____

Patient or Guardian Signature:

_____

To:

Lino Lakes Family Dentistry
591 Apollo Drive
Lino Lakes, MN 55014
Phone: (651) 786-7630
Fax: (651) 786-6485
E-Mail: info@linolakesfd.com

From:

_____
_____
_____
_____
_____