**MOUNTLAKE FAMILY DENTISTRY**

**22725 44TH AVE. WEST**

**MOUNTLAKE TERRACE, WA 98043**

**AUTHORIZATION TO RELEASE X-RAYS**

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**I request and authorize** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **to release x-rays of the above mentioned patient to:**

**Name:** Mountlake Family Dentistry

22725 44th Ave W Suite 100

Mountlake Terrace, Wa 98043

**Email:** Mountlakedental@gmail.com

**Patient/Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**