Patient X-Ray release form
Dr. Alicia Robertson, DDS
9417 Flower Ave
Silver Spring, MD 20740

I, _____ by signing this release form agree to have my X-rays withdrawn from this dental office and be delivered to the following address:

Adress:_____

_____

_____

I relieve Dr. Robertson's office from any responsibility regarding my x-rays, fully understanding that any loss or damage caused during the shipping is not her responsibility. And I also wish to notify that I will no longer be getting service at this office.

Patient's Signature_____
Date: