Dr. Sharon Walden and Associates
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X-ray Request Form

Date: X_________________________

I, authorize you to release any relevant records and radiographs for

X

Name of patient(s)

Please list relevant history:

Date of last recall: __________________________________

Date of last new patient exam: __________________________________

Date of last bite wings/Pa's: __________________________________

Date of last panoramic film: __________________________________

I release you from all responsibility or liability that may arise from this authorization.

Signed: X____

Date: X____

Name of Previous Dentist: X_______________________________________