X-RAY REQUEST AND RELEASE FORM

Date: ___/___/___

Patient Name(s) ______________________________________

Requested by (if other than the pt.) ___ _____________________

Relationship to Patient: ________________________________

X-ray(s) to be sent to :

Jennifer Sokolosky D.M.D., PA.
6100 Day Long Lane
Suite 105
Clarksville, Maryland 21029

drjenniferdmd@gmail.com

I ,______________________, authorize the release of the x-rays requested.

Signature: ____