Pristine Smiles PLLC
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Authorization to Receive X-rays Records

I, (print patient/guardian name) _____, hereby authorize the doctor and team of Pristine Smiles PLLC to receive copies of my X-rays to info@pristinesmilesorlando.com

A. Patient's Full Name: _____

   Date of Birth: _____

   Phone number: _____

   E-mail address: _____

B. Current Practice Name: _____

   E-mail address: _____

Signature: _____ (patient or guardian name)

Printed:_____ (patient or guardian name)

Date:_____

Please e-mail us with the completed form

Please call or text our office with any questions

Sincerely,
The Team at Pristine Smiles PLLC

Team Member Initials:_____

Date Received:_____