Pristine Smiles PLLC
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Authorization for Release of X-rays Records

I, (print patient or guardian name) _____, hereby request and authorize the doctor and team of Pristine Smiles PLLC to release copies of my X-rays to:

A. Myself
(Please provide your e-mail address you would like us to send your copy to).

E-mail: _____

Expiration of authorization to transfer records (6 months if left blank):

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 Released:_____