

X-Ray Release Form

Date _____

Patient name _____

Patient address _____

City _____ State _____ Zip _____

I authorize the release of dental x-rays or copies of such and request that they are sent to:

Doris L. Woodruff, D.D.S.

1405 W. Frankford, #112

Carrollton, TX 75007

(972) 466-1884

Patient Signature