polished dental
healthy smiles for the entire family

X-RAY RELEASE FORM

Patient Name

Date of Birth

I hereby authorize the release of my x-rays to:

Dental Office & Phone Number

Do you want us to inactivate your chart and cancel any upcoming appointments?
Please Circle: YES NO

Signature Date

Where to submit your request:
Mail: 1700 E Interstate Ave
Bismarck, ND 58503
Email: info@polished-dental.net
Fax: 701-222-1783