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X-RAY RELEASE FORM

PREVIOUS DENTIST:_____

ADDRESS:_____CITY:_____
_

STATE:_____ ZIP:_____PHONE( )_____-____

I authorize the release of my dental X-rays, or copies of such to Dr. Douglas P. Chang D.D.S.,
You may email copies to:dentaworkshawaii1@gmail.com or mail copies to the address below:

DentaWorks Hawaii
1060 Young Street #305
Honolulu, HI 96814

Print Patient Name:_____

Signature of patient,
parent or guardian:_____ Date_____