

# X-ray Release Form

I, \_\_\_\_\_ give authorization to the office  
of \_\_\_\_\_ to release my child/children  
\_\_\_\_\_ dental x-rays to Merrick Pediatric Dentistry  
for my child's continued treatment. You can email these copies  
to: [MPD1756@gmail.com](mailto:MPD1756@gmail.com)

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent/ Guardian- Print

\_\_\_\_\_  
Parent/ Guardian-Sign