



Chanhassen Family Dentistry, P.A.  
8116 Mallory Court  
Chanhassen, MN 55317  
952-443-3368  
[office@chandent.com](mailto:office@chandent.com)

### AUTHORIZATION RELEASE FORM

All patients requesting x-rays must have the following release completed and signed.

By signing below, I am authorizing the release of my x-rays.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

If there are multiple family members under the age of 18 that are requesting release of x-rays and the parent/guardian has signed above, please list additional patient names below.

\_\_\_\_\_

Please send x-rays to the address listed below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

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

Relationship to patient: \_\_\_\_\_

(if signed by a personal representative of patient)