

Authorization for X-Ray release

I, _____(your name), hereby give
authorization for _____(your previous
dentist), to release copies of my x-rays to Kinberly Antrim, DDS.

Patient Signature and Date

Please send digital x-rays to:

Antrimdds@gmail.com

Or mail film x-rays to:

Kinberly Antrim, DDS

7880 Wren Ave Suite A-113

Gilroy, CA 95020

Thank you