



## X-RAY RELEASE FORM

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

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

I hereby authorize the release of my x-rays and/or records from \_\_\_\_\_ to:

Bright Dental Studio  
1110 College Dr., Suite 110  
Bismarck, ND 58501  
[info@brightdental.studio](mailto:info@brightdental.studio)  
Ph: 701-712-0770  
Fax: 701-975-3050

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date