Suttons Bay Dental Center
Conservative Esthetic Dentistry

X-RAY RELEASE FORM

I, _____, give authorization for _____to release my dental x-rays to Suttons Bay Dental Center for my continued dental treatment.

_____ _____
Date Patient name - Print

_____
Patient name – Sign

Please send to: Suttons Bay Dental Center
1299 SW Bayshore Dr
Suttons Bay, MI 49682

231-271-6700 phone
231-271-5093 fax

info@suttonsbaydental.net

Date	**X-rays Released**	**Released by**
_____	_____	_____