**Patient X-Ray release form**
**Dr. Rebecca Armel, D.D.S.**
**490 Post St. Suite 1690**
**San Francisco, CA 94102**

**I, ______________________________ , by signing this release form agree to have my X-rays withdrawn from this dental office and be delivered to the following address:**

**Address: ___________________________________________**

**___________________________________________**

**___________________________________________**

**I relieve Dr. Armel's office from any responsibility regarding my x-rays, fully understanding that any loss or damage caused during the shipping is not her responsibility.**

**Patient's Signature: __________________________________ Date: _____________**