Dr. Snehal Lakhkar
1351 South County Trail B2-205
East Greenwich, RI 02818
401-885-6460 Email: elitedentistryri@gmail.com

X-Ray Release Form

I, ______________________________DOB________________ hereby authorize and
(Please Print)
Request the release of x-rays taken of me to:

☐
Dentist/Dental Office

OFFICE NAME: ____

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE #: ____

☐
Digital Copy

EMAIL ADDRESS: ____

☐
Other ____

SIGNATURE: ____

DATE: ____