

Marianne Spamer, D.D.S

2810 Crow Canyon Rd

Suite #201

San Ramon, Ca 94583

(925) 838-0066

Fax : (925) 838-4475

Cell: (925) 389-6204

Fax to:

X-RAY REQUEST AND RELEASE FORM

Date: ___ / ___ / ___

Patient Name: _____

Requested by (if other then the patient): _____

Relationship to Patient: _____

Exam Date(s) Requested: _____

X-Ray(s) to be Sent/Faxed to: _____

I _____ authorize the release of the X-Rays(s) requested above.

Signature

Date