

DC Dental Spa
730 24th St NW, Ste 9
Washington, DC 20037
(202) 833-8724
Fax (888) 750-7049

X-Ray Release Form

Date: _____

I request to obtain my x-rays.

- Please send them to: _____
- To be picked up at your office
- Please email them to: _____

I take full responsibility for my x-rays, dental care, and have paid all necessary fees to my account.

Print name: _____

Signature: _____

Date: _____