Mobile Dentistry of Arizona

P: 480-313-3310
F: 480-772-4032
Scheduling@MobileDentistryofAZ.com

Consent To Release X-Rays

This authorizes Mobile Dentistry of Arizona to furnish any and all x-ray films, including digital formats,

for _____ **to** _____.
Patient Name | New Provider/Doctor

Patient Information

Patient Name:_____

Date of Birth:____/____/_____ **SSN:**_____ **Marital Status:** S M Other **Sex:** M F

Patient Living Address:_____
Street | City | State | Zip Code

Patient Phone:_____ **Patient Email Address:**_____

Power of Attorney Information

POA Name:_____ **Date of Birth:**____/____/_____

POA Address:_____
Street | City | State | Zip Code

POA Phone:_____ POA **Email Address:** _____

New Provider Information

Office: _____ **Doctor Name:** _____

Address: _____
Street | City | State | Zip Code

Phone Number: _____ **Fax Number:** _____ **Email:** _____

X _____
MUST BE SIGNED HERE **Patient / Responsible Party / Power of Attorney** **Date**