I give permission to release my x-rays to:

Dr. Katherine McGrath
9679A Main Street
Fairfax, VA 22031
703-978-6556
dentistkamcgrathdds@verizon.net

Thank you,

SIGNATURE _____ DATE_____

PRINT NAME _____

Additional family members:

Patient _____ DOB _____

Patient _____ DOB _____

Patient _____ DOB _____

Patient _____ DOB _____