My East Cobb Dentist, PC
4200 Providence Rd
Marietta, GA 30062
voice: 770-579-6400 Fax: 770-579-6100
www.eastcobbdentist.com

Authorization for Release of Dental X-rays

I, (print patient or guardian name) _____,
DOB _____ hereby authorize the doctors and staff of My East Cobb Dentist, PC to release a copy of my x-rays to:

Full Dr. Name _____

Street Address _____

City, Zip Code _____

Practice telephone number: _____

Practice E-mail address:_____

Patient Name _____DOB_____(if different)

Signed (patient or guardian name) _____Date_____