Refusal of X-Rays Release Form

Patient Information

Patient First Name	Patient Last Name	Date of Birth	Patient Phone Number	Email

X-ray Refusal/Release

I have been informed X-Rays (pictures of teeth) need to be used to properly identify ad diagnose issues with my mouth. I refuse to allow dental x-rays to be taken of my mouth and/or that of my child. I release Dr. Esther Jeong DDS, and her staff from all liability in failing to find, diagnose, and/or properly treat all dental conditions that require the use of x-rays.

Signature of Self 18 & Over

Sign

Signature of GUARDIAN of under 18

Sign