



## X-Ray Request and Release Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Requested By: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Exam Date(s) Requested: \_\_\_\_\_

X-Rays to be sent/faxed to: \_\_\_\_\_

I \_\_\_\_\_ authorize the release of x-rays released above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Blake Quigley  
Email: [info@benddentalwellness.com](mailto:info@benddentalwellness.com)  
Phone: (541)-640-5322  
461 NE Greenwood Ave. Ste. C  
Bend, OR 97701