



Fox Valley
Dental Care
Aurora

243 E Indian Trail
Aurora, Illinois 60505
(630) 896-1086

I, _____, am giving permission to Dr. Dokhanchi to email my radiographs (X-Rays) to any specialist for future appointments. I understand that there is a risk an unauthorized person may view the X-Rays. I will accept that risk. The alternative of copying the X-Rays and hand delivering or mailing them has been offered.

Name: _____

Date Of Birth: _____

Signature: _____

Date: _____