

RELEASE OF RESPONSIBILITY  
(X-RAYS)

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

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

I absolve Dr. Clark from all responsibility in the diagnosis of my mouth condition and its treatment, since he/she is not able to see under existing restorations, between or through teeth, or check bone loss or any other condition that could be apparent from a complete examination including the necessary x-rays which I have refused.

Signature

Date