**Alexandria Family Podiatry**
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# X-RAY RELEASE FORM

I, ___________________________________________, acknowledge receipt of _______x-rays of my ____________foot/feet and understand that these MUST be returned to this office. I also acknowledge that a $100 deposit fee will be required from me at the time of check-out of the x-rays. Once the x-rays are returned to the office in its original condition, the $100 deposit fee will be returned to me. Otherwise, damage to the x-rays or failure to return the x-rays will result in the forfeiture of my deposit.

_________________________________________________________________
Patient's Signature Date

_________________________________________________________________
Doctor's Signature Date

_________________________________________________________________
Parent or Legal Guardian Date