

The Family Foot Care Center

**679 Hospital Road
Commerce Ga 30529
706-335-4884**

**711 Rose Lane
Toccoa Ga 30577
706-886-9441**

**2109 Hwy 129 S
Cleveland Ga 30528
706-865-0666**

RELEASE OF X-RAY'S

DATE: _____

I _____ **HERBY**

REQUEST MY X-RAYS TO BE RELEASED TO

_____. **I**

UNDERSTAND THE FAMILY FOOTCARE CENTER'S

X-RAYS MUST BE RETURNED WITHIN 30 DAYS OF

TODAYS DATE.

Patient signature

Date

Witness signature

Date

DATE CHECKED OUT: _____

DATE CHECKED IN: _____