**CHART NO.** _____

# Informed Refusal X-Ray Consent Withheld

**Patient Name** _____
*First* *Middle* *Last*

I, the undersigned, have voluntarily elected not to have diagnostic radiographs taken to help with the diagnosis and treatment planning of my oral health condition. This is being done against the recommendation of my dentist. I do not hold my dentist liable for any failure to diagnose, or any misdiagnosis due to lack of the recommended x-rays. I assume full responsibility for any conditions relating to my dental health that may have not been diagnosed or misdiagnosed due to lack of radiographs.

*I understand the previous statements and have had my questions answered.*

**Patient/Guardian Name** _____
*First* *Middle* *Last*

**Patient/Guardian Signature X** _____ **Today's Date** ___/___/___

**DHC Clinician Signature X** _____ **Today's Date** ___/___/___