

# X-Ray Release Form

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I, \_\_\_\_\_ hereby authorize and request the release of x-rays taken of me to:

*(Please Print)*

Me (The Patient)

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist/Dental Office

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_ Phone: \_\_\_\_\_

Digital Copy

Email Address: \_\_\_\_\_

*By selecting Digital Copy you take full responsibility that these private dental records are going to be sent over the Internet without security and the ability to verify that receiving party successfully obtained the files. Furthermore, there is an understanding that the file format may not be compatible. We issue all x-rays in JPEG format.*

*I understand that these X-rays are part of the original dental records that belong to McDonough/Hiram Center for Family Dentistry LLC. I also understand that a processing fee of \$10 will be charged to obtain copies of all dental records and x-rays and we require 48 hours from the time of signature.*

*Please note that this form MUST be filled fully including your Signature, Date & Time, and the Drivers License Number that matches your original number when originally given to the practice.*

**Patient's Signature:**

**Date & Time of Request:**

**Driver License #** \_\_\_\_\_

**OFFICE USE ONLY**

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**Approved By:**

**Dentist Signature:**

**Date & Time of Release:**

**Reason for Release:**