

X-RAY Release Form

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 the 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 the X-rays are part of the original dental records that belong to TF Dental Group LLC the parent company of the dental office. We require 72 hours from the time of signature to process your request.

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. Please email the completed form to xrays@tf-dental.com.

Patient's Signature: _____

Date & time of request: _____

Driver License # & DOB: _____

Office you visited(Check one)

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Hiram | <input type="checkbox"/> Stonewalk |
| <input type="checkbox"/> McDonough | <input type="checkbox"/> Tech |
| <input type="checkbox"/> Acworth | |

Reason For Release:

- Second Opinion Moving Insurance Change Not Happy with Practice