X-ray Release Form

I, _____hereby authorize and request the release of x-rays taken of me to:

(Please Print)

◯ Me (The Patient)

Digital Copy Email Address: _____

◯ Dentist/Dental office

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 Seaside Dental office. We require 48 hours from the time of signature to process your request.

Patient's Signature: _____Date& time of request: _____

Reason for Release:

◯ Second Opinion ◯ Moving ◯ Insurance Change ◯ Not Happy with Practice