Healthy Smiles X-Ray Release Form

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

☐ Myself (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 x-rays in JPEG (.jpg) and/or the DEXIS (.dex) format for the convenience of any other dental office using the same system.

I understand that the x-rays are part of the original dental records that belong to Healthy Smiles Dental. Furthermore, I understand Healthy Smiles Dental requires 72 hours from the time of signature to process your request.

Please note that this form MUST be filled fully including your Signature as well as the Date and Time.

Patient Signature: _____

Date & Time of Request: _____

Reason for Release:

☐ Second Opinion ☐ Moving ☐ Insurance Change ☐ Not happy with Practice

Office Use Only _____

Approved By: _____

Dentist/Manager Signature: _____

Date & Time of Release: _____