

## X-RAY Release form

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

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 the receiving party successfully obtained the file. Furthermore, there is an understanding that the file format may not be compatible.

I understand that the X-Rays are part of the original dental records that belong to 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. Please email the completed form [titaniumdentalstudio@gmail.com](mailto:titaniumdentalstudio@gmail.com)

Patient's Signature: \_\_\_\_\_

Date & Time of Request: \_\_\_\_\_

### Reason for Release

- Second Opinion
- Moving
- Insurance change
- Not happy with Practice