Dental X-Ray Release Form

Dear Dr. _____ in _____
(Previous Dentist's Name) (City, State)

I, _____ hereby authorize and request the release of my
(PRINTED NAME OF PATIENT)

current dental x-rays (within the last 5 years) to be released to:

ORLANDO FAMILY DENTISTRY, LLC
312 Route 31 North
Hopewell, NJ 08525
(609) 466-1332 fax (609) 466-1569

☐ I authorize the release of my ***digital and my film x-rays*** to
office@orlandofamilydentistry.com
email address of Orlando Family Dentistry, LLC

By selecting digital copy, I am taking full responsibility that my private dental x-rays will be sent over the internet without security. This may be accessible by a third party. I am requesting JPEG format be released; however, I am aware that the dental file format may not be compatible for Orlando Family Dentistry, LLC.

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I understand that the x-rays will be part of my original dental records that belong to my previous dentist and Orlando Family Dentistry, LLC.

_____ _____
Signature of Patient or Parent if Patient is a minor Date