Authorization for the release of x-rays

I authorize Finesse Dental Care to release X-rays of:

Patient Name:_____ DOB:_____

X-ray Release Policy:

- I understand that the released information may no longer be protected by federal privacy
  regulations. (HIPPA)
- I understand that this request for information may take up to one week to process.
- I understand that there may be a fee for duplication of x-rays and/or medical records and that this fee must be collected prior to the release of records.

Please release the following information:

- Most recent bitewing X-rays ___
- Panoramic X-ray ___
- Most recent Full Mouth Series ___
- Most recent Periapical X-rays ___

Delivery Information:

Send Email to recipient/Office name: _____

Email address: _____

Patient/Legal Guardian Name (printed): _____

Patient/ Legal Guardian Signature: _____ Date: _____