DESTEFANO
DENTISTRY

X-RAY RELEASE FORM

Patient Information

Name: _____ Date of Birth: _____

Address: _____
Address Line 1

_____ Phone Number : _____
Address Line 2

_____ Email : _____
City ST ZIP Code

Authorization for Release of Dental X-Rays

I, _____ (Patient or Legal Guardian Name), authorize the release of my dental X-rays from:

Dental Office Releasing X-Rays

Office Name: _____

Address: _____
Address Line 1

_____ Phone Number : _____
Address Line 2

_____ Email : _____
City ST ZIP Code

X-Rays to Be Sent To

Office Name: _____ Phone Number : _____

Address: _____ Email : _____
Address Line 1

_____
Address Line 2

_____ Preferred Method of Delivery
City ST ZIP Code

☐ Email ☐ Mail ☐ Pick-up

I understand that by signing this form, I authorize the release of my dental X-rays to the designated recipient. I acknowledge that once these records are released, the original dental office is no longer responsible for them.

_____ _____
Signature Date

Office Use Only

Processed by: _____

Date of Release: _____

Method of Release: _____

Comments: _____

X-Rays to Be Released

☐ Full Mouth Series (FMX)

☐ Bitewings

☐ Periapical X-Rays

☐ Panoramic X-Ray

☐ Other: _____