Belknap Dental Associates
40 Chestnut Street, Suite 2
Dover, NH 03820
Telephone: (603) 742-4735
Fax: (603) 742-9911
www.belknapdental .com

Authorization to Release Records/X-Rays

Date of request: _______________

I, _________________________________ , hereby authorize and request the release of x-rays taken of me and/or my dependents:

Patient Name(s): ____ Date of Birth:_____________

____ Date of Birth:_____________

____ Date of Birth:_____________

____ Date of Birth:_____________

____ Date of Birth:_____________

Please release to:

☐ **Patient**

ADDRESS:____

CITY/STATE/ZIP____ PHONE:______________________

☐ **Dentist/Dental office**

ADDRESS:____

CITY/STATE/ZIP____ PHONE:______________________

☐ **Digital Copy**

EMAIL ADDRESS:____

By selecting Digital Copy, you are giving Belknap Dental permission to email your and/or your dependents over the internet. We transfer all x-rays in JPEG format.

Patient's Signature: ____ Date:_____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Signature: ____

Relationship to Patient: ____

Reason for Release:

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