Belknap Dental Associates
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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