RIDGE COMMONS
FAMILY DENTISTRY

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AUTHORIZATION FOR THE DIGITAL RELEASE OF DENTAL X-RAYS

Patient Name ____________________________ Phone Number ________________________

DOB _____/_____/__________

I, ______________________________________ hereby authorize the doctor and staff of Ridge Commons
Patient's Name or Parent/Legal Guardian

Family Dentistry to duplicate and release dental x-ray(s) pertaining to the above named patient to my provider of choice listed below:

Name of Dental Practice/Dentist: ____

Address: ____

Telephone Number: ____

Email Address: ____

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED: (*Please select one*)

□ Referral (oral surgeon, orthodontist, endodontist, etc.)

□ Transfer of records

Reason(s) for leaving ____

□ Other (*please specify*) ____

____/______/__________
Signature of Patient or Parent/Legal Guardian Date

____
Please print name of Patient or Parent/Legal Guardian Relation to Patient