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AUTHORIZATION TO RELEASE DENTAL X-RAYS

I ________________________________ hereby authorize ______________________________ to release my

x-rays to Dr. _____________________________________ for my continued treatment.

____
Receiving Office Address

____
City, State, Zip, Telephone

Name of Patient:_____________________________ Date of Birth:_____________________

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here:_______________________.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be in effect upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorization Representative of Patient:

____
Signature

____
Name (Printed)

____
Relationship to Patient