CHARLES A. SMITH, DDS & ASSOCIATES

Specialists for Aesthetic Dentistry

X-RAY Release Form

I, _____ hereby authorize and request the release of x-rays taken of (patient name)

_____ Date of Birth: _____

Children (if applicable) :

(patient name) _____ Date of Birth:_____

(patient name) _____ Date of Birth:_____

(patient name) _____ Date of Birth:_____

(patient name) _____ Date of Birth:_____

to:

☐ **Digital Copy to Dentist/Dental Office –**

Office/Doctor Name_____

CITY/STATE/ZIP_____

EMAIL:_____

☐ **Digital Copy to Self/Parent/Legal Guardian**-

Email Address:_____

By selecting Digital Copy you take full responsibility that the private dental records are going to be sent over the Internet without security and the ability to verify that receiving party successfully obtained the files. Furthermore, there is an understanding that the file format may not be compatible. We issue all x-rays in JPEG format. I understand that the X-rays are part of the original dental records that belong to **Dr. Charles A. Smith & Associates**. We require 72 hours from the time of signature to process your request.

Please note that this form MUST be filled out completely including Signature and Date.

Please email the completed form to: info@boeblingendental.com

Patient's (Guardian) Signature: _____

Date of request: _____

Reason For Release:

Second Opinion _____Moving _____Insurance Change_____ Unhappy with Practice_____