Dental Xray Release Form

I hereby authorize Riverdale Dental to provide

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with copies of my dental xrays with respect to any dental care and treatment that I have received. I understand that the specific type of information to be disclosed includes x-rays and digital images. This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Patient Name:

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Patient Signed: ____________ Date: ____________

Parent, legal guardian, or POA of the patient, if patient is unable to sign for themselves:

Signature: ____________ Date: ____________

Email address to where records should be sent:__________________________________

Will the patient be returning to our office?

○ Yes ○ No