AUTHORIZATION FOR

RELEASE OF X-RAYS

I authorize Desert Valley Dental / Joseph J. Eberle, DDS to release the x-ray films of:

Patient Name: _____ DOB: _____

X-RAY Release Policy

- I understand that the released information may no longer be protected by federal privacy regulations (HIPAA).
- I understand that this request for information could take up to approximately one week to process.
- I understand that a fee of $_____ will be charged for the duplication of x-rays/dental records and must be collected prior to release. *Per Health and Safety Code Section 179515, we reserve the right to charge for duplication.*
- Please release the following information (*check all that apply*):

  ☐ Most recent dental bitewing x-rays.

  ☐ Most recent panoramic or full series x-ray(s) less than 3 years old.

  ☐ Most recent dental periapical (PA) x-ray(s).

- Please select a delivery method: ☐ Hold for pickup. ☐ Send to below…

  _____

  _____

  _____

  _____

I understand that I might be taking original x-rays and am responsible for these films. In the event that they become lost, I understand that I must retake these x-rays at my expense. By signing below, I agree and understand all of the above.

_____ _____

Patient/Legal Guardian Signature Date

OFFICE USE ONLY:	*X-Rays Released By*: _____	*Release Date*: _____
☐ *Digital X-Rays Released*	*Digital Print Date:* _____	*Original's Released*? ☐Yes ☐No
☐ *Film X-Rays Released*	*X-Rays Duplicated By*: _____	*Duplication Date*: _____

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