Summit Family Dentistry, PLLC
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(814) 923-4199 (fax)
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X-RAY Release Form

I,_____hereby authorize and request the release of x-rays taken of me to:
(Please Print)

☐ Me (the patient)

ADDRESS:

_____

CITY/STATE/ZIP_____ PHONE: _____

☐ Dentist/Dental office

ADDRESS:

_____

CITY/STATE/ZIP_____ PHONE: _____

☐ Digital Copy

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 Summit Family Dentistry, PLLC. We require 72 hours from the time this document is received to process your request.

Please note that this form MUST be filled fully including your Signature, Date & Date of Birth. Please email the completed form to SFD@SummitFamilyDentistry.net.

Patient's Signature: _____

Date: _____

DOB: _____