Harris Dentistry
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Authorization to Release Dental X-Rays

I hereby authorize the release of my dental x-rays to the dentist or entity named below. I also hereby understand that the privacy of this information can no longer be guaranteed and waive Dr. Harris for any responsibility for the release of this information.

Patient's Full Name Date of Birth

Patient's (Legal Guardian) Signature Date

Please provide us with the contact information of the dentist or entity you wish to receive a copy of your dental x-rays.

Dentist's/Entity Name E-mail

Address Suite #

Office Phone # Office Fax #