Harris Dentistry

2600 N. Military Trail
Suite 348
Boca Raton, FL 33431

Phone: 561.241.7272
Fax: 561.241.4986

DENTAL X-RAY RELEASE FORM

Dentist:_____ Email address:_____

_____ _____

Mailing address City, State

_____ _____

Office Phone# Office Fax

I,_____ hereby authorize and request the release of my current
PRINTED NAME OF PATIENT dental x-rays (within the last 5 years) to be released to:

Harris Dentistry
2600 N. Military Trail #348
Boca Raton, Fl 33431
561-241-7272 fax: 561-241-4986

I authorize the release if my digital x-rays to: **info@harrisdentistry.com**

email address of Scott Harris, DMD.

By selecting digital copy, I am taking full responsibility that my private dental x-rays will be sent over the internet without security. This may be accessible by a third party. I am requesting JPEG format or DEXIS if available.

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I understand that the x-rays will be part of my original dental records that belong to my previous dentist and Harris Dentistry.

_____ _____

Signature of Patient Date