Authorization for Release of X-Ray(s) Records

Requested X-Rays Type: ___FMX ___Panoramic ___BW's

I hereby authorize the doctors and staff of Center of Carewell Dentistry, PLLC ("CCD") to release the requested dental radiographs for:

_____
(Patient's Full Name)

_____
(Patient's Date of Birth)

_____
(Patient's Address)

_____
(Address Line 2)

Please forward X-rays to: (Authorized recipient)

_____
(Full Dr.'s Name)

_____
(Practice Name)

_____
(Address)

_____
(Address Line 2)

_____
(Phone)

_____
(Fax #)

_____
(Email Address)

I understand that CCD may deny this request under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law; I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by CCD who did not participate in the CCD's decision to deny my request.

I understand that CCD will notify me of its decision to approve or deny my request to access or obtain a copy of the requested information within seven (7) days of receiving this request.

Federal law prohibits the use of medical/dental information in anticipation of (or for use in) a civil, criminal or administrative proceeding, or as may otherwise be required by applicable law.

Dated: _____

Signed: _____
(Patient or Guardian Signature)

Printed Name:_____
(Patient or Guardian Signature)

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