Dental X-Ray Release Form

Dear Dr. ______________________________ in _______________________________ (Previous Dentist's Name) (City, State) I, ________________________________ hereby authorize and request the release of my (PRINTED NAME OF PATIENT) current dental x-rays (within the last 5 years) to be released to:

SEUBERT FAMILY DENTISTRY, LLC

OFFICE@PORTAGEDENTISTS.COM

260 W Cook St. Portage, WI 53901 (608)742-2331 fax (608)742-4308

I authorize the release of my digital and my film x-rays to office@seubertfamilydentistry.com email address of Seubert Family Dentistry, LLC 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 be released: 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 Seubert Family Dentistry, LLC.

____ Signature of Patient or Parent if Patient is a minor

___________________ Date