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 TF Dental Group LLC the parent company ofthe dental office. We require 72 hours from the time of signature to process your request.

Please note that this form MUST be filled fully including your Signature, Date & Time, and the Drivers License Number that matches your original number when originally given to the practice. Please email the completed form to xrays@tf-dental.com.

Patient's Signature: _____

Date & Time of Request: _____

Driver License #: _____

☐ Hiram ☐ Stonewalk

☐ McDonough ☐ Tech

☐ Covington ☐ Acworth

Reason For Release:

☐ Second Opinion ☐ Moving ☐ Insurance Change ☐ Not Happy with Practice