Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____, hereby authorize the doctor and staff of Modern Dentistry to release records or knowledge concerning my dental health to:

Full Dr. Name _____

Street Address _____

City, Zip Code _____

Practice telephone number: _____

Practice e-mail address: _____

I specifically request that you release copies of:

___ all x-rays

Signed (patient or guardian name) _____

Printed name (patient or guardian name)_____

Please complete this form and fax it to (770) 993-6892.
Payment is required to cover the cost of duplication and/or copying patient records.
In accordance to Georgia law all original records remain the property of Modern Dentistry but patients are entitled access to copies of all records. (GA Code 31-33-2)