Titanium Dental P.L.L.C.
107 Lake Ave, NY 10707
Tel: 914-961-3324

# X-RAY Release form

I,_____ hereby authorize and request the release of x-rays taken of me to:

☐ 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 the receiving party successfully obtained the file. Furthermore, there is an understanding that the file format may not be compatible.

I understand that the X-Rays are part of the original dental records that belong to the parent company of the 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. Please email the completed form *titaniumdentalstudio@gmail.com*

Patient's Signature:_____
Date & Time of Request:_____

Reason for Release

- ☐ Second Opinion
- ☐ Moving
- ☐ Insurance change
- ☐ Not happy with Practice