Kakouras Family Dentistry
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AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

DENTAL XRAY RELEASE FORM

I, ___________________________________, authorize Kakouras Family
(Patient/Legal Guardian Name)
Dentistry to release copies of my dental x-rays with respect to any dental care and treatment to:

____
(Name and address to which the records will be sent)

I understand that the specific type of information to be disclosed may include a report of examinations, findings, treatments, prognosis, and copies of any/all other records, including x-rays, which pertain to me.

I understand that Kakouras Family Dentistry has up to 30 (thirty) days to process all records.

I hereby release Kakouras Family Dentistry from all legal responsibility or legal liability that may arise from the release of such information. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire (90) ninety days after the date below.

A reproduced copy of this authorization shall be valid as the original.

Patient(s) Printed Name(s): ______________________________DOB _____________

Patient Signature: ____

Relationship to Patient: ______________________________________

Patient Address: ____

Date: ____

Translator: ____