

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.

Patient's Signature: _____

Date & time of request: _____

SUNSHINE DENTAL CARE, LLC

Man Hong Sandra Chau D.D.S.

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