Sal Taiym, DDS
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AUTHORIZATION TO RELEASE DENTAL X-RAYS

Patient's Name: _____ Date of Birth: _____

Parent's Name: _____

I request and authorize Jupiter Kids Dentistry & Orthodontics to release my child's dental X-Rays to:

Name: _____

Phone: _____

Email: _____

Address: _____ City:_____ Zip Code:_____

My authorization is for: ☐ Release of X-Rays

Additional Comments: _____
_____
_____

The authorization is given freely with the understanding that: Any and all records, whether written or oral in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as provided by law. A photocopy or fax of this authorization is as valid as the original. Treatment, payment, and operation of our business may not be conditioned upon this authorization. The resale of information authorized may be subject to re-disclosure by the recipient.

Release of records to a dental office of your choice: No Charge
Release of records to self (parent/legal guardian): $25 Charge

Parent's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 30 DAYS AFTER IT IS SIGNED.

e-mail to: info@jupiterkidsdentistry.com