ALPHA DENTAL
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Midlothian, TX 76065
Phone & Fax: (972) 954-9339
Email: info@alphadentaltexas.com

RELEASE FORM FOR DENTAL X-RAYS

I,________________________________hereby authorize and request the release of dental x-rays to:
(Please Print Patient Name)

☐ Me (The Patient) ☐ Dental Office

METHOD: ☐ Digital Copy ☐ Mail ☐ In- Person Pickup

DENTAL OFFICE _________________________ PROVIDER NAME ___________________________________
ADDRESS:____
CITY/STATE/ZIP____
PHONE:_________________________
EMAIL ADDRESS:____

By selecting Digital Copy you take full responsibility that the private dental records will be sent over the Internet without security and the ability to verify that receiving party successfully obtained the files. Alpha Dental will take necessary precautions to safeguard content. Furthermore, there is an understanding that the file format may not be compatible. X-rays are part of the original dental records that belong to Alpha Dental. **Allow at least 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, Driver's License, and DOB. (This form may also be printed and emailed to info@Alphadentaltexas.com.)

Patient's Signature:_____________________________________

By typing in your name, you are signing this Agreement electronically. You agree your electronic signature ("E-Signature") is the legal equivalent of your manual/handwritten signature on this form. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature.

Date& time of request:__________________________________

Driver's License :________________State ____ DOB _____/_____/____

THERE IS A **$30 FEE** FOR PATIENTS WHOSE XRAYS WERE COMPLETED AS PART OF A PROMOTIONS PACKAGE, AND WHOM HAS NOT DONE TREATMENT WITH ALPHA DENTAL