Patient Record Release Form

Name of Patient: _____Date of birth:____/____/____

Address of Patient: _____

_____

I hereby authorize **Dr. Theresa Robinson, DMD** to release to:

_____
(name & address of person/office receiving information)

_____

_____

_____
(e-mail address, if applicable) **(phone number)**

dental x-rays and _____for the period of care from initial visit to present. I understand that this information will be used for diagnostic purposes.

Dr. Theresa Robinson, DMD, PA is hereby released from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein. I also understand that digital transmission of this information is subject to possible hacking through either a secure or an insecure transmission and I release Dr. Theresa Robinson, DMD, PA and Staff from liability should such hacking occur.

_____
Signature of Patient Date

_____
Signature of Witness Date

_____
Print Witness name

The first request for x-rays from our office is complimentary. There will be a $10.00 fee for all other requests made hereafter.