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Authorization for Release of Dental Records

I hereby voluntarily authorize the use and/or disclosure of my dental information as described below. This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except if action has already been taken in reliance upon it, by giving written notice to Ankeny Children's Dental. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Ankeny Children's Dental.

Transfer/Release of X-Rays for:

Patient's Name: _____ **Patient's Date of Birth:** _____

_____ **I hereby request copies of my x-rays held by** _____
to be transferred to Ankeny Children's Dental

_____ **I hereby request copies of my x-rays held by**
Ankeny Children's Dental to be transferred to:

_____

_____

_____

Signature of Patient or Legal Guardian: _____

Today's Date: _____

FOR OFFICE USE:

Date of Last Visit: _____

Date of Last Bitewings:_____

Date of Last PANO:_____

Date of Last Cleaning:_____

Date of Last Fluoride:_____