

Patient Consent Form for Duplication and Release of X-rays

Date: _____

I authorize _____ to release any current x-rays, last prophylaxis and dental exams that you have on file for the following patient(s).

Name DOB

Name DOB

Name DOB

Name DOB

Release records to: _____ or: _____
Chambersburg Dental Associates _____
101 Loudon Road _____
Mercersburg, PA 17201 _____
Email:pandrewscda@comcast.net _____

Thank you for your prompt response.

Sincerely,

(Signature of Patient or Parent/Guardian)

PA Code 33.209 section C states: "Within 30 days of receipt of a written request from a patient...an exact copy of the patient's...radiographs...shall be furnished to the patient or to the patient's new dentist. This service shall be provided either gratuitously or for a fee reflecting the cost of reproduction." Section D states: "The obligation to transfer records ...exists irrespective of a patient's unpaid balance for dental services or for the cost of reproducing the record."