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:
Chambersburg Dental Associates
225 Walker Road
Chambersburg, PA 17201
Email: chmbsdental@comcast.net
717-264-0169 (fax)

or:
_____
_____
_____
_____

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."