RADIOGRAPHIC & PHOTOGRAPHIC PRECISION
DENTAL

Authorization to Release Protected Health Information

Patient or Representative _____ authorizes **C-Dental X-Ray, Inc.** to release x-ray and diagnostic records to:

- ❑ Self
- ❑ Other Requestor _____

for purpose of providing the requestor with **C-Dental X-Ray Inc.** diagnostic records.

This authorization shall expire 30 days from today's date. Expiration date: _____

By signing this request you agree to the following:

I understand that I have the right to revoke this authorization, and I must do so in writing. I understand that any such revocation will not affect any actions taken by C-Dental X-Ray Inc. in reliance on this authorization before its revocation. I understand that the Requestor may be able to redisclose protected health information provided by C-Dental X-Ray Inc., and that the protected health information will no longer be covered by the federal privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996.

Patient Signature _____ Date _____

OR

Representative to Patient _____ Date _____

Relationship _____

Patient Email (self) _____

Requestor Email (other) _____

Imaging Center Visited:

- ❑ San Francisco - Downtown
- ❑ San Francisco - West Portal
- ❑ San Mateo
- ❑ San Rafael
- ❑ Mountain View
- ❑ San Jose
- ❑ Menlo Park
- ❑ Pleasanton
- ❑ Walnut Creek
- ❑ Oakland

Send to info@cdental.com