Patient Authorization for Release of X-Rays

Belgrade Dental Associates
412 W Main, Suite 1
Belgrade, MT 59714
406.388.8006

Purpose of Release:

- □ Co-Diagnosis / Second Opinion
- □ Transfer from ***Belgrade Dental Associates*** to another Practice
- □ Transfer from another Practice to ***Belgrade Dental Associates***

Patients Name(s): _____

Address: _____

Phone Number(s): _____

I authorize the professional office of: _____ to release all radiographs and records to the below named practice or the patient. The above named patient, in requesting a records transfer, releases ***Belgrade Dental Associates*** of any legal liability in regards to the confidentiality of transferred information.

Transfer Office (If self, please write your name or the name of the person picking up the information):

Practice Name: _____

Full Address: _____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____

Date: _____