Calcaterra Family Dentistry

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Consent to Release Dental Records

I, (print name) ___________________________________ hereby authorize the release of my dental records from _______________________________ to Calcaterra Family Dentistry.

Please also release the records of my dependents named here: _____________________________________

To the dentist from which the records will be sent:

- *We are a completely paperless office and we utilize Dexis as our imaging software.*
- *If you are a Dexis office, please email the x-rays in Dexis format.*
- *If you utilize digital radiography but not Dexis, please email the x-rays in JPG format and indicate the date(s) taken.*
- *If you do not use digital radiography, please duplicate the x-rays to the highest quality possible and mail them to us.*

_____________________________________ ____
Patient Signature Date If minor, Signature of Parent or Guardian

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Witness Signature Date