REQUEST TO INSPECT OR COPY DENTAL RECORD

Please allow (3) three business days for records to be made available and/or forwarded to the requested provider.

I HEREBY REQUEST ACCESS TO DENTAL X-RAYS Today's Date: _____

_____

Patient's Name (Please include middle initial) Birth Date Patient's Phone Number

_____

Patient's Current Address

Please choose one: ___ Records requested for Personal/Referral Use ___ Seeing another provider
If you are requesting your records due to seeing another provider please provide the Reason You are Leaving Our Office: _____

X-Rays to be sent to:

_____

Office Name Doctor(s) Name

_____

Office Address-City/State/Zip

_____

Email Address

- ☐ I would like my records to be sent securely. I understand messages sent securely cannot be intercepted or seen by a third party, but that a temporary password will need to be created to access it. ***If having xrays sent to a provider, I have checked with the email recipient to ensure that they can access secure messages.**
  - **I UNDERSTAND THAT IF I DO NOT CHECK WITH THE PROVIDER/EMAIL RECIPIENT PRIOR TO HAVING XRAYS SENT AND THEY CANNOT OR WILL NOT ACCEPT SECURE MESSAGES AND THEY HAVE TO BE RE-SENT I WILL BE RESPONSIBLE FOR $25 DUPLICATE RECORDS REQUEST**
- ☐ I would like my records to be sent via normal email. This way a password is not required to access the contents of the email.

Please return this form via either fax or email to:

Via email: patient@dentaltlc.com Via Fax: 404.255.0923

Cone Beam CT Scans: I understand that there is a $50 fee for a copy of each CT Scan provided to me and that this will be due at the time of receipt and/or mailing and that any CTs mailed will also incur a mail fee of $9.95.
I understand that you may charge me for reasonable clerical costs incurred in making additional records available for inspection.

Copies or Transfer: I understand that for multiple requests for copies or transfer, Dental TLC may charge me any additional reasonable clerical costs incurred in making the records available. I further understand that you may charge me your actual costs for copies of any x-rays.

_____

Signature **Date**

S:\Front Office Documents\X-ray & Record Release.doc