Citrus Dental of Inverness, P.A.
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Inverness, FL 34453
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AUTHORIZATION TO TRANSFER X-RAYS/RECORDS

Patient: ____

Address: ____

____

D.O.B.: ______________________________________

Authorized release of x-rays/records from Citrus Dental of Inverness to:

Dr. ____

Address: ____

____

Phone: ____________________________________ FAX: ____________________________________

Patient permission for release:

Signature: ____

I, the patient, do not authorize the information to be disclosed or to be used for any other reason than the above.

(Protected by Federal Confidentiality rules 42CFR Part 2. Federal rules prohibit further disclosure unless expressly permitted by written consent of the patient to whom it pertains)