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AUTHORIZATION TO TRANSFER X-RAYS/RECORDS

Patient: _____

Address: _____

D.O.B.: _____

Authorized release of x-rays/records from:

Dr. _____

Address: _____

Phone: _____ FAX: _____

To Drs. Holland and Pichardo of Citrus Dental of Inverness, P.A.

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.

NOTE: Records, including x-rays, may be mailed or e-mailed to the appropriate address 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)