Authorization to Release Recent X-rays to the Office of Christopher M. Anderson, DMD

If your previous dentist or specialist, etc., has recent x-rays, that may save you some unnecessary expense by sharing them with our office. Use this form to request those recent x-rays **FROM** your previous dentist, etc. be sent **TO** our office.
****Note that your previous dentist, etc. may prefer/require you to use their own release form.****

I hereby request and authorize this dental/medical facility:

Practice Name _____
Practice Phone#: _____
Practice Email Address (optional): _____

to release and disclose, **this one time only**, copies (electronic copies preferable) of recent X-rays (Panoramic x-rays taken within the last five (5) years, and bitewing and other x-rays taken within the last two (2) years) for the following patient(s):

Full Legal Name of Patient requesting disclosure: _____
Other family members also requesting disclosure: _____
Patient's Date of Birth: _____

Please release those records to:

Christopher M. Anderson, DMD, LLC
1225 Johnson Ferry Rd., Suite 660
Marietta, GA 30068
770-973-6494
www.dmdga.com

X-rays may be sent digitally encrypted to the office of Christopher M. Anderson, DMD by using this email address:
xrays@dmdga.com

Signature of Patient/Personal Representative: _____
Date: ____/____/____
If Personal Representative, please complete the following:
Print Full, Legal Name: _____
Representative Signature: _____ **Relationship to Patient:** _____
Legal proof of representation may be requested at our discretion.