Mark A. Antonis,DDS, LLC

CONSENT TO RELEASE DENTAL RECORDS

Date: _____

_____ ***DOB*** _____
(Patient Name)

_____ ***DOB*** _____
(Patient Name)

_____ ***DOB*** _____
(Patient Name)

I authorize the release of ***my dental records to include current digital and/or film x-rays*** to/from:

Mark A. Antonis, DDS, LLC
1333 Easton Ave., Bethlehem, PA 18018
610/866-5391 (fax) 610/866-5421
email-mantonisdental@gmail.com

Authorization: By selecting digital copy, I am taking full responsibility that my private dental x-rays will be sent over the internet without security. This may be accessible by a third party. I am requesting JPEG format be released; however, I am aware that the dental file format may not be compatible for Mark Antonis, DDS, LLC.

Patient Signature _____
(parent or guardian if minor)

Previous/New Dentist _____

Phone or fax #_____

Email address _____