GATE CITY DENTAL

Drs. McNeil & Goodrich
2001 North Church St. Suite 211
Greensboro, NC 27405
336-292-4331(p) 336-316-7022(f)

X-Ray Release Form

I, _____Date of birth _____hereby authorize and request the release of x-rays taken of me to:

____ Me (the patient)

Address: _____

City/State/Zip: _____Phone:_____

____ Dentist/Dental Office

Address: _____

City/State/Zip: _____Phone:_____

____Digital Copy

Email Address: _____

*By selecting a digital copy **you take full responsibility** that these private dental records are going to be sent over the internet without security and the ability to verify that the receiving party successfully obtained the files. This also means that our digital x-ray format (jpeg) might not be compatible with their system.

I understand that the X-rays are part of the original dental records that belong to Drs. McNeil and Goodrich. Please make sure that the form is completed in its entirety including your signature and date that the records were requested.

Patients Signature: _____ Date: _____

Reason for Release:

____Second Opinion ____Moving ____Insurance Change ____Not Happy with Practice