Dental Records Request

To Whom It May Concern:

Name (Last,First): _________________________________ Birthday: _____________

The patient above requests and/or authorizes the release of their radiographs and pertinent clinical information and request that copies of this information be sent to McKee Dental.

For Radiographs, it is only necessary to send:

1. Bitewing radiographs if less than one (1) year old.
2. Full mouth series or Panoramic if less than five (5) years old.

Please forward diagnostic film copies by mail to the address on the bottom of the page.

For digital radiographs, **paper copies and/or faxes of copies are not diagnostic**. Please send proper digital records if you no longer use film.

Digital copies can be emailed to: Xrays@McKeeDental.com
Alternately, they may be burned to a CD-Rom and sent by mail.

This authorization extends to me and the following (under 18) members of my family:

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Note: Each family member over 18 must sign their own records release.

Signature: ___________________________________ Date: ______________

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