ELITE DENTAL, LLC
IMPLANT, COSMETIC, ORTHODONTIC, & SEDATION DENTISTRY

# X-Ray/ Records Release Request

Please allow at least (3) three business days for X-Ray/Records to be made available and/or forwarded

**X-Ray/ Records requested for:** ☐ Personal Use ☐ Seeing another dentist

If you are requesting your X-Ray/Records due to seeing another dentist please provide the reason you are leaving our office:_____

_____

Patient's Name (full name) Birth Date Phone #

_____

Patient's Address

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request they be **transferred to:**

_____

Office Name Doctor(s) Name

_____

Office Address-City/State/Zip

_____

Email Address Phone #

_____ _____

Patient's (or Legal Guardian's) Signature Date

**Fee for duplication** : Please pay by cash or credit card. Checks cannot be accepted. If paid by credit card, please fill out authorization form. Payment must be provided before we can duplicate records.

## X-Ray Request

☐ Email- $25 (Please select the email option you want below)

☐ I would like my records to be sent **via secured email**. I understand messages sent securely cannot be intercepted or seen by a third party, but that a password/account will need to be created to access it. ***If having xrays sent to a provider, I have checked with the email recipient to ensure that they can access secure messages. I UNDERSTAND THAT IF I DO NOT CHECK WITH THE PROVIDER/EMAIL RECIPIENT PRIOR TO HAVING XRAYS SENT AND THEY CANNOT OR WILL NOT ACCEPT SECURE MESSAGES AND THEY HAVE TO BE RE-SENT I WILL BE RESPONSIBLE FOR $25 DUPLICATE RECORDS REQUEST

☐ I would like my records to be sent via **normal email**. This way a password/account is not required to access the contents of the email.

☐ CD- $30 for pickup (shipping not included)

The majority of dental offices would need just the x-rays to be transferred, but if you'd need anything else like treatment/clinical notes, you can request it for an additional fee. Cost of duplication depends on how many pages and desired format.

1525 Livingston Ave., Suite B, West St. Paul, MN 55118
Phone: (952)-432-1716 Fax: (952)-432-7633 Email: info@elitedentalllc.com

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## Credit Card Payment Authorization Form for X-Ray/ Records Release

(Do not fill this form if paying by cash)

Patient Name: _____ (print clearly)

I _____ give Elite Dental permission to charge the amount of $_____
(Full Name of Cardholder)

to the credit card listed below for the cost of X-Ray/Records release of the above named patient. In the event that there are any problems with my credit card payment, I understand the X-Ray/Records will not be released until the problem is resolved.

Account type/ Circle One: Visa MasterCard Discover American Express

Name on Card: _____

Credit Card Number: _____

Credit Card Expiration Date: _____

Card Verification Code (last 3 digits on back of card): _____

Billing Address_____

City, State, Zip_____

Phone # _____

Email _____

I certify that this is my credit card and I am legally authorized to give permission for its use. By completing and signing this agreement, I hereby give my fully informed consent to the duplication of X-Ray/ Records for the above named patient. I understand that once the services have been completed and the payment has been applied, I will not be entitled to any refunds. I agree not to dispute resultant charges.

Cardholder Signature: _____ Date: _____

Cardholder Name: _____

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