Drs. Neighbors, Herod & Moretti

P.O. Box 158

Midlothian, VA 23113

info@midlodental.com

X-RAY RELEASE FORM

Patient Name: ____

Date of Birth: ____

Address: ____

Phone: ____

This is to authorize the office of Drs. Neighbors, Herod & Moretti to release any information concerning the above patient to the following address/email:

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EMAIL: ____

Please transfer records prior to: __________________________________

By signing below, I understand that the above office will have access to my personal health information on file at Drs. Neighbors, Herod & Moretti's office to include, but not limited to, clinical notes and imaging files. I understand that my digital images/records may be sent electronically to the above email address.

PATIENT/GUARDIAN SIGNATURE

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RELATIONSHIP IF OTHER THAN PATIENT **DATE**

_______________________________________ ________________________