UNIVERSITY SQUARE DENTAL ASSOCIATES
Kristen Leong, DMD LLC
3901 MARKET STREET • BOX 1936 • PHILADELPHIA, PA 19104
TELEPHONE: (215)-662-1030 • FAX: (215)-662-1015
EMAIL: UniversitySquareDentalAssc1@gmail.com
universitysquaredental.com/

Patient Request for Release of Dental Radiographs

Patient Information:

Full Name: _____

Date of Birth: _____

Phone Number: _____

Send Records To:

Self / Name of Dentist: _____

E-Mail Address (Delivery via encrypted email): _____

***Encrypted email will expire in 30 days, please open and download your record accordingly. You will have to make an account with a password to view the files.**

There is $25.00 charge for releasing your dental radiographs and upon receipt of payment of this charge, we will promptly release the radiographs.

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient:_____