Frank C. Raymer D.D.S. INC
14785 Jeffrey Rd. Suite #100
Irvine CA 92620
(949) 551-2606
FAX (949) 551-1904
Fcrdds2015@gmail.com

X-Ray Release Form

I, _____, hereby authorize and request the release of x-rays taken of me to:

☐ Me (The Patient)

☐ Dr. Frank C. Raymer

Address: 14785 Jeffrey Rd Suite #100

Irvine CA 92620 (949)551-2606

Previous Dentist/Facility (where x-rays were taken)

Address: _____

City/State/Zip: _____ Phone: _____

☐ Digital Copy

Email Address: _____

By selecting Digital Copy you take full responsibility that the private dental records are going to be sent over Internet without security and the ability to verify that receiving party successfully obtained the files. Furthermore, there is an understanding that the file format may not be compatible. We issue all x-rays in JPEG format.

We require 72 hours from time of signature to process your request.

Please note that this form MUST be filled fully including your signature, date, time and the Driver's License number that matches your original number when originally given to the practice. Please email the completed form to fcrdds2015@gmail.com

Patients Signature: _____

Date & Time of request: _____

DOB: _____

Reason for Release:

☐ Second Opinion ☐ Moving ☐Insurance Change ☐Not happy with Practice