FOSTER CITY DENTAL CARE

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Signature Release For Duplication Of X-rays

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You have requested a duplicate copy of your x-rays. In order to protect your privacy and adhere to California HIPAA laws please sign below. You may return this form to us via email, fax, regular mail or in person. We will fulfill your request once your completed release is received. Thank you.

I, _____(printed name), hereby authorize FOSTER CITY DENTAL CARE to provide a copy of my dental x-rays to:

□ Mail Paper Copy To Name: _____

Address: _____

_____

OR

□ Mail Digital Copy To Email: _____

Phone (just in case): _____

I understand that I am responsible for the cost of $_____ for expenses incurred in duplicating these x-rays.

_____ _____

Signature Date