

Gateway Dental

7462 Limestone Dr.
Gainesville, VA. 20155
703-753-3346 fax 703-753-8836
drmekouar@gateway-dental.net

X-Rays/Records Release

Patient _____
Date of Birth _____ Contact Phone # _____

I authorize Gateway Dental to send copies of my *X-Rays and Records* to:

Name _____
Address _____

Phone # _____

Fax # _____

Email _____

- ✓ I understand that this authorization is voluntary.
- ✓ Payment, enrollment or eligibility for benefits for my health care will not be effected if I do not sign this form
- ✓ Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the practice or individual receiving the information

I here by authorize the release of X-Rays/Records via mail, email or fax to the above location and fully understand my rights and responsibilities.

(Signature)

(Date)

(Relationship to Patient)