Dental Care of Burlington
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Authorization to Release Protected Health Information (PHI)

I, ___________________________, give permission to _________________________

to release radiograph images taken during the time I was a patient at the office.

Please release images to: (name of doctor/office, address, telephone number, email address):

Reason for request:

I understand that all providers will do their best, in accordance with HIPAA, to protect my PHI.

_______________________________ ___________________________________

Signature of Patient **Date**