DR. PRIVETTE & ASSOCIATES, P.A.
"Family Dentistry with Concern"

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RELEASE OF DENTAL XRAYS

I, the undersigned, authorize the dental office of Carlos J. Privette, D.D.S. to release the dental x-rays and/or records of (patient name and account #) _____ to _____. I also understand that the original x-rays are to remain in the possession of this dental office for ten years by State and Federal Law, and thereafter I can get the originals. The cost of the duplication of x-rays is $25.00 and the cost of a narrative by the doctor is $ 35.00.

_____ _____

(Responsible Party Signature) (Date)

_____ _____

(Authorized Dental Office Agent) (Date)