AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ hereby authorize and request
Patient or Guardian Name

_____
Dental Provider

to disclose and provide copies of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to:

_____
Name of dentist, specialist, consultant, or insured

_____
Address

_____
Phone Fax

_____
Email

These records include, but are not limited to radiographs, clinical photographs, and perio charting. Please include any examination records that would be useful in future treatment of patient named above.

I release the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.
Dated this_____ day of_____, 20_____

_____ _____
Signature of patient Print Name

_____
Patient Phone Patient Date of Birth