PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, ____ hereby request and authorize
Patient or guardian name

____ to disclose and provide copies
Practice or dentist name

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 new dentist, specialist, consultant, patient, attorney, insurer, etc.		
Street address:		
City:	State:	Zip:
Telephone number:		

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records. Referral and consultation recommendations and reports, diagnostic models, and other related materials.

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed: ____________________<<patient_birthdate>> Date: _____________
Patient or Guardian

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Reason for Release:

□ *Moving*
□ *Insurance*
□ *Changing Dentist-Reason* ____
□ *Other*____