MOUNTAIN DENTAL

PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, hereby request and authorize
Patient or Guardian Name

_____ to disclose and provide copies of any
Practice or Dentist Name

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 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 or Guardian (if minor) *Patient's date of birth* *Date*

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