Middleburg Smiles
Kelly M. Lincoln, DDS
When Dental Excellence Matters

Patient Authorization to Release Confidential Information

I _____ hereby request and authorize
Patient or guardian name

_____ to disclose and provide copies of any and all clinical
Practice or dentist name

treatment records and information concerning my care, which is in the possession of this person or entity, to:

Kelly M Lincoln DDS, PLLC
MiddleburgSmiles
P.O. Box 386
Middleburg, VA 20118
540-687-6363
info@middleburgsmiles.com

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:_____ Date: _____
Patient or Guardian