Patient Authorization to Release Confidential Information

I, _____, hereby request and authorize _____
Patient or Guardian Name (please print) *Practice or Dentist Name*

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 new dentist, specialist

_____
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:_____ Date:_____
Patient or Guardian