Powell Family Dentistry

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Please email x-rays & perio chart to office@richlandfamilydentistry.com

Authorization to Release Confidential Patient Information

I _____ hereby request and authorize
Patient or Guardian Name

_____ to disclose and provide copies and
Practice or Dentist Name

any 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, ect.

_____
Address

_____
City State Zip Code

_____
Telephone Number

These records included, 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.

Signature: _____ Date: _____
Patient or Guardian