Patient Authorization to Release Confidential Information

I, ___________________________, hereby request and authorize ___________________________________
Patient or Guardian Name (please print) *Dentist Name and Phone Number*

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:

Dental Associates of Wethersfield
20-30 Beaver Road
Suite 102
Wethersfield, CT 06109
email: daow@sbcglobal.net

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