DENTAL ASSOCIATES OF WETHERSFIELD
FAMILY AND COSMETIC DENTISTRY

PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, hereby request and authorize

Patient Name (Please Print) *Date of Birth*

_____ _____

Practice or Dentist Name *Phone/Fax 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 Rd., Suite 102
Wethersfield, CT 06109
Email: daowfd@yahoo.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 signature