AUTHORIZATION TO RELEASE RECORDS AND/OR INFORMATION

Date: ________________________________

Name of Patient: _____________________

You have requested we release your records to ________________________. In order to complete this, please sign and return the written release authorization to our office.

I hearby authorize Dientes Community Dental Clinic to release the information in the dental records of:__________________________________

I hereby release Dientes Community Dental Clinic from any liability related to disclosure of confidential or privileged information.

Signature:____
(Patient or parent)

Address:____

City/State/Zip:____

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