306 US Route 1 Building B North
Scarborough, Maine 04074
www.sweetdental.com
207.396.4373

AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

I, ____ hereby request and authorize
(Patient or guardian name)

____ to disclose and provide copies of any and all
(Practice or dentist name)

clinical treatment records and information concerning my care, which is in the possession of this person or entity, to:

DENTAL PRACTICE:_______________________________________

ADDRESS:____

EMAIL:____

PHONE#:____

Regarding the following patient(s):

PATIENT NAME:____

DATE OF BIRTH:____

Please forward any Bitewing x-rays, FMX or PAN within the last 5 years and probing depth chart

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 all liability arising from compliance with this request and disclosure of the requested information.

Signature: ____ Date: ______________