Litchfield Dental Associates, LLC

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AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

I hereby request and authorize **Litchfield Dental Associates, LLC** to disclose and provide copies of any and all clinical treatment records and information concerning care of _____to:
Print name of patient

Please fill out the following information for where the records are to be sent:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

Those records include, but are not limited to, personal patient information, medical and dental history, examination records, radiographs, clinical photographs, treatment plans, treatments records, referral and consultation recommendations and reports, diagnostic models, and any other related materials.

I expressly release from liability **Litchfield Dental Associates, LLC** from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed: _____ Date: _____
Patient, Guardian, or Authorized representative

Office use only:

Initials: _____ Date: _____

Mailed Records _____ Emailed Records _____ Faxed Records _____