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Eastview
FAMILY DENTAL

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, hereby request and authorize
PATIENT OR GUARDIAN

_____ 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:

_____
NAME OF DENTIST, SPECIALIST, CONSULTANT, PATIENT, ATTORNEY, INSURER, ETC.

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
TELEPHONE

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: _____
PATIENT OR GUARDIAN

Date: _____