PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name:_____

Date of Birth:_____

I hereby request and authorize _____(dental office)

to disclose and provide Legible Copies of any and all clinical treatment records and information, including updated Radiographs (xrays), concerning my care ,which is in the passion of this person or entity to:

Email (preferred) to:

kathy@shettydmd.com

OR

Dental Designs of New England
Dr. Shetty
Attn: New Patients Documents
297 Daniel Webster Highway, suite 6
Merrimack, NH 03054

Signed:_____(patient or parent/guardian)

Date:_____