Sample Form: Patient Authorization to Release Confidential Information

I,, Patient or Guardian Name (please print)	, hereby request and authorize _		
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 new dentist, specialist, consultant, patient, att	torney, insurer, etc.		
Street Address			
City	State	Zip	Telephone Number
These records include, but are not limited	to: personal patient information,	medical and dental hist	ories, examination records,
radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports,			
diagnostic models, and other related mate	rials.		
I expressly release from liability the above	named person or entity from an	/ and all liability arising f	rom compliance with this
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request and disclosure of the requested in	formation.		
Signed:	Date:		
Patient or Guardian			

This sample form is for illustrative purposes only. Your form's content and layout may be different. We encourage you to modify this form to suit your individual practice and patient needs. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice. Published by CNA and provided through the Dentist's Advantage insurance program and the National Society of Dental Practitioners. Copyright © 2019 CNA. All rights reserved. Published 5/19.