Records Release Authorization

Patient Name ____

I,____request and authorize

____
Previous Dentist

____
Address

____
Phone Number

To disclose and provide copies of any and all clinical treatment records and information concerning my care in their possession to:**Dr, Dhillon M.A. DDS & Dr. Sandhu M.S. DDS.**

These records include, but are not limited to, personal patient information. Medical and dental histories, exam and treatment records, radiographs, clinical photographs, referral and consultation recommendations and reports, diagnostic models and related materials.

I release from liability the above named (“previous dentist”)from any and all liability arising from compliance with this request and disclosures of the requested information.

Signed:____Date:______________________

Witness:_______________________________________Date:______________________

Email: info@orindafamilydentistry.com

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