# Creative Smiles Dental Clinic

## Authorization to Release Confidential Patient Information

I, ________________________________ hereby request and authorize
PATIENT OR GUARDIAN NAME

_________________________________ 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:
PRACTICE OR DENTIST NAME

____________________________________________________________
NAME OF NEW DENTIST, SPECIALIST, CONSULTANT, PATIENT, ATTORNEY, INSURER, ETC.

____________________________________________________________
ADDRESS

____________________________________________________________
CITY / PROVINCE / POSTAL CODE

____________________________________________________________
TELEPHONE NUMBER

**These records include, but are not limited to: personal patient information, dental and medical 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: ___________________________________ Date: ____________________
PATIENT OR GUARDIAN