AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient's Name(s): ______________________________ Date(s) of Birth: ______________________________

______________________________ ______________________________

I request and authorize ____ to release healthcare information of the patient above.

Name: **Hamburg Family Dental**

Address: **469 West State Street**

City: **Hamburg** State: **PA** Zip Code: **19526**

Office 610-562-7348

Fax 610-562-3454

info@hamburgfamilydental.com

The record includes but is not limited to: personal information, medical and dental histories, radiographs, clinical photos, treatment plans, treatment records, referral and consultation 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.

Patient Signature: ______________________________ Date Signed: ______________________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.