GILLIS & DALTON
FAMILY DENTISTRY

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PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I,_____hereby request and authorize
(name of person requesting transfer of records)

_____
(name of person or entity in possession of records)

to disclose and provide copies of any and all clinical treatment records and information pertinent to my care, which is in the possession of this person or entity, to Gillis & Dalton Family Dentistry PLLC. I expressly release from liability the above named person from any and all liability arising from compliance with this request and disclosure of the requested information.

Signature:_____

Date:_____