Malwin & Malwin
Family Dentistry
343 W. Miami Avenue
Venice, FL 34285

"Serving The Dental Needs Of Sarasota County For Over 56 Years"

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Patient Authorization To Release Confidential Information

I, _____ hereby request and authorize
Patient or Guardian Name

_____ to disclose and provide copies
Practice or Dentist Name

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, Attorney, Insurer, Etc.

_____
Address

_____
City **State** **Zip** **Telephone Number**

These records include, but are not limited to: personal patient information, medical and dental 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