Canton Valley Dental

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PATIENT AUTHORIZATION FORM TO RELEASE CONFIDENTIAL INFORMATION

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize

Patient or Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release and provide

Dentist

copies of all clinical treatment records and information concerning my care, which is in possession of this person or entity, to:

Canton Valley Dental

P.O. Box 456

Canton, CT 06019

office@cantonvalleydental.com

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, and other related materials. I release from liability the above named person or entity from all liability arising from compliance with this request and disclosure of the requested information.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_