Canton Valley Dental

Charles J. Keefe, D.M.D., LLC

191 Albany Turnpike Theresa F. Keefe, D.M.D.

P.O. Box 456 Matthew P. Keefe, D.M.D.

Canton, CT 06019 Janot Bente, D.M.D.

 Jo-Ann Castellone, D.M.D

Phone: (860)693-0887

Fax: (860)693-1079

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_