CRANSTON COSMETIC DENTISTRY

Record Release

PATIENT INFORMATION							
First Name		Last Name				Birth Date	
Address		City		State		Zip Code	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Release to:

Cranston Family & Cosmetic Dentistry
30 Chapel View Blvd., Suite 210
Cranston, RI 02920
Phone: (401) 944-7556 Fax: (401) 228-7188

I, undersigned below, authorize and direct the medical provider(s) listed below to release/obtain to Cranston Family & Cosmetic Dentistry all records requested.

❑ Release ❑ Obtain

Provider:

_____

_____

_____

Telephone # _____ Fax # _____

Please include complete medical records, including any additional diagnostic testing.

The Facility and its doctors are released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Notice to Person or Agency Receiving this information: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FORM COMPLETION			
Signature of Patient, Parent or Guardian		Date	

IF PATIENT IS A MINOR			
Form signed by		Relationship to Patient	