FAIRMOUNT
DENTAL
Robert S. Atwell DDS | 715 Hammond St. Bangor, ME 04401 | (p)207.945.6493 (f)207.945.6003 |
frontdesk@fairmountdental.me

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAIRMOUNT DENTAL

_____

_____

_____

Patient name, address and date of birth

I hereby request and authorize you, your authorized employees and/or agents, permission to send copies, disclose and/or discuss my dental health care information in your possession to Fairmount Dental.

_____

_____

_____

Name of Dental Practice, address, tel. # and email address

My authorization to release includes:

Copies of my medical, social and dental histories, clinical exam and diagnostic records, radiographs, clinical photos, treatment plans, treatment progress records, referral and consultation recommendation and notes, diagnostic and working casts, pharmaceutical, medical and dental lab prescriptions and results, office notes and other related records that would assure continuity of my dental care.

I understand I may request a copy of this authorization. By signing below, I herby release the holder from all liability, and claims pertaining to this transfer of healthcare information. I understand that any refusal to release or revocation of this consent may result in improper diagnosis or treatment. I understand that I may review all information before its release.

Signed: _____Date _____ _____

Patient **Parent Guardian / Authorized Representative**