REQUEST FOR RELEASE OF RECORDS

I hereby request and authorize the office of _____ to disclose and provide copies of all and any clinical treatment records and information concerning my care, which is in the possession of this person or entity.

Please send my records to:

Angela Manning DDS PC
66 Milton Road Suite A13
Rye, NY 10580
(914) 967-1123
Fax (914) 967-2776
info@ryedds.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 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.

Signature: _____(person authorizing transfer)

Relationship:_____

Patient Name(s): _____

_____

Address:_____

_____

Date: _____