Galvin & Round Family Dentistry

Patient Authorization to Release Confidential Information

I, _____ hereby authorize _____
(Patient or Guardian Name) (Practice or Dentist Name)

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

Galvin & Round, P.C.
622 Hebron Avenue, Suite I05
Glastonbury, CT 06033

galvinroundpc@sbcglobal.net

These records include, but are not limited: 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.

Signed:_____ Date:_____
(Patient or Guardian)

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