Authorization to Release Confidential Information

I, ____, hereby request and authorize
Patient or Guardian name

Luba G. Richter, DMD. PA. to disclose and provide copies of records and information concerning the care of ____,
Patient's Name Date of Birth

to this specific person/entity, or to any dental provider:

____
Name of new dentist, specialist, consultant, patient, attorney, insurer, etc.

____
Address

____
City State Zip Phone #

For the purpose of:

______ Permanent transfer to a new provider
______ Consultation for: __________________________________
______ Other: ____

Authorize the following information to be disclosed by initialing:

______ Complete Records

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, diagnostic models, and other related materials.

______ Financial Records ______ Radiographs & Pictures

______ Treatment Notes

I expressly release 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 Parent / Guardian