# Consent for Release of Dental Records and Disclosure of Protected Health Information

I, ______________________________________________ hereby request and authorize
Patient, Parent or Guardian's Name

Levitt & Prasatthong, D.D.S., P.A. ______________ to disclose and provide copies
Practice or Dentist Name

of any and all clinical treatment records and information concerning my child's care—or my care as I am over 18 years of age—which is in the possession of this person or entity, to :

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

______________________________________________________________________
Address

______________________________________________________________________
City State Zip Telephone Number

E-mail address: ____________________________________

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.

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 for the following patients

______________________________ ______________________________
Name and D.O.B Name and D.O.B

______________________________ ______________________________
Name and D.O.B Name and D.O.B

__________________________________________ ________________
Signature of Patient or Guardian Date



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