** PATIENT AUTHORIZATION TO RELEASE CONFIDENTITAL INFORMATION**

I, _____ (D/O/B) _____, hereby request and authorize:

Previous Practice or Doctor's Name

Mailing Address

City, State, Zip–Code, Telephone Number

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

Wellspring Dental Group
57 Northeastern Blvd. Suite 201
Nashua, NH 03062
Phone :603-521-8411 Fax:603-518-5170 or email to wellspringdentalnashua@gmail.com

These records include, but are not limited to: personal patient information, medical and dental histories, examination 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.

Signature

** Please note: Receipt of your records in advance of your appointment will provide Wellspring Dental Group with your dental history and may reduce costs.