Dunes Dental Services, Inc.

AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

I, _____ hereby request and authorize
Patient or guardian name

_____/_____
Practice or dentists name phone number

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

Dunes Dental Services
100 Sutter Drive Suite 106
Surfside Beach, SC, 29575

Telephone (843) 215-2140
Fax (843) 215 2141
Email: office@dralinamuntean.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, 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.

Signed: _____ Date: _____
Patient or Guardian