Englund and DesRoches Dentistry

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Spokane, WA 99208
Phone (509)326-8170
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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ authorize and request

_____
_____
_____
_____

To release:

___ All dental/medical records ___ All current radiographs

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___ Regarding my care to: (or)

___ Regarding _____'s care to:
(Minor/Dependent)

_____
_____
_____
_____

I expressly release from liability the above named person and/or entity from any and all liability arising from compliance with this request and disclosure of the requested information. This release is valid for ninety days.

Signed, _____ Date: _____
(Patient or Guardian)
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