CNA Sample Form: Patient Authorization to Release Confidential Information

I, ______________________________, hereby request and authorize ______________________________
Patient or Guardian Name (please print) *Practice or Dentist Name*

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

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

____
Street Address

____
City *State* *Zip* *Telephone Number*

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

This sample form is for illustrative purposes only. Your form's content and layout may be different. We encourage you to modify this form to suit your individual practice and patient needs. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice.

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