

**Patient Authorization to Release Confidential Information**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize the release of dental records for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From Former Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be released to: Dicus Family Dentistry

15 McCabe Drive, Suite 201

Reno, NV 89511

office@dicusfamilydentistry.com

These records include, but are not limited to: personal 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 Parent/Guardian)

Michael T. Dicus, D.M.D.

15 McCabe Drive, Suite 201

Reno, NV 89511

(775) 828-7246 phone

(775) 852-2300 fax

[office@dicusfamilydentistry.com](mailto:office@dicusfamilydentistry.com) (secure email)