



PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ hereby request and authorize
(Patient or Guardian Name)

(Practice or Dentist Name and Address)

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

Mark A. Tromblay, D.M.D., P.C.
2440 M Street, NW
Suite 601
Washington, DC 20037

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 material.

I expressly release from liability the above named person or entity from all liability arising from compliance with this request and disclosure of the requested information.

Signed: _____
(Parent or Guardian)

Date: _____