wellspring
DENTAL GROUP

** PATIENT AUTHORIZATION TO RELEASE CONFIDENTITAL INFORMATION**

I, _____ (D/O/B) _____, hereby request and authorize:

_____

Previous Practice or Doctor's Name

_____

Mailing Address

_____

City, State, Zip–Code, Telephone Number

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

Wellspring Dental Group
155 Main Dunstable Rd. Suite 140
Nashua, NH 03060
603-521-8411 Fax 603-521-8670 or email to wellspringdentalnashua@gmail.com

These records include, but are not limited to: personal patient information, medical and dental histories, examination 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.

_____

Signature

** Please note: Receipt of your records in advance of your appointment will provide Wellspring Dental Group with your dental history and may reduce costs.