PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____herby request and authorize
Patient or Guardian 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:

Christopher M. Anderson, DMD, LLC
1225 Johnson Ferry Rd., Suite 660
Marietta, GA 30068
770-973-6494

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, photographs, treatment plans, treatment records, referrals 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 name