Kristin M. Saville, D.D.S.

cosmetic & family dentistry

AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

I, _____ hereby request and authorize
Patient or guardian name

_____ to disclose and provide copies of
Practice or dentist name

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

Kristin M. Saville DDS, PC
Name of new dentist, specialist, consultant, patient, attorney, insurer, etc.

2060 Charlie Hall Blvd Suite B
Address

Charleston, SC 29414
City State ZIP

843-766-0266 savilledental@gmail.com
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