Kristin M. Saville, D.D.S.

cosmetic & family dentistry

2060 Charlie Hall Blvd, Suite B Charleston, SC 29414 843.766.0266
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AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

I, ________________________________ (patient or guardian) hereby request and authorize

____________________________ (Former Practice or Dentist Name) to disclose and provide copies of any and all clinical treatment records and information concerning my care,

which is in the possession this person or entity, to:

Kristin M Saville, DDS or Fred Danziger, DDS
2060 Charlie Hall Blvd, Suite B
Charleston, SC 29414
frontdesk@kristinsavilledds.com
office: 843.766.0266
fax: 843.766.0849

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referrals 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 the request and disclosure of the requested information.

Signed: ______________________________ Date: ______________________________