MARTIN B. SANDERS, DDS, LTD
DAVID H. SANDERS, DDS
929 S. MAIN STREET #100
LOMBARD, IL. 60148-3387
630-620-0929 FAX.630-620-1458
TOOTHDR12@ATT.NET

PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

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

Martin B. Sanders, DDS, David H. Sanders, DDS.
929 S. Main St. # 100
Lombard, Il. 60149-3387
630-620-0929 FAX. 630-620-1458

e-mail:TOOTHDR12@ATT.NET

These records include, but are not limited to personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment records, referral and consultation recommendations and reports, diagnostic models and other related materials.

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

signed:_____ date:_____

patients date of birth: _____