SAWTOOTH DENTAL
RELEASE OF CONFIDENTIAL RECORDS/INFORMATION

I _____ hereby request and authorize
Patient or Guardian Name

_____ to disclose and provide copies of any and all
Dentist or Practice with my records

clinical records and information concerning my care, which is in the possession of

this person or entity to: Sawtooth Dental, PLLC
1437 Parkview Dr.
Twin Falls, ID 83301

Phone: 208-733-4515
Fax: 208-733-2757
Email: sawtoothdental@yahoo.com

These medical records include, but are not limited to: personal patient information, medical & dental records, radiographs, clinical photographs, treatment plans, and records, referrals and consultation information and records and 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 this requested information.

Signed: _____ Date: _____
Patient or Guardian