PATIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, Patient or Guardian name : ____

hereby request and authorize 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:

Kenneth E. Kay, DMD, LLC, MAGD
250 W. Clinton Street
Gray, GA 31032

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:_________________