Authorization to Release Confidential Information

I ____ herby request

and authorize____ at

_______________________________ to disclose and provide copies of

any and all clinical treatment records and information concerning my care

to: Dr Nancy Patel, DMD. 2 Lakeside Dr, Levittown, PA, 19054.

Tel: 215-946-9469 Fax: 215-946-3520 Email: drnancypateldmd@gmail.com.

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

Signed_____________________________ Date ________________