RECORDS RELEASE FORM

To Whom It May Concern,

I, ______________________________________, authorize Main Street Dental to release any information regarding my dental health, in accordance with the attached Notice of Privacy Practices (NOPP). A copy of this signed, dated Consent shall be as effective as the original. I release and hold Main Street Dental, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent. I authorize disclosure of the entire dental record concerning patient ______________________________ to the following:

Name	Relation	Phone Number
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________

Thank you,

____
Patient Signature

______________________________ ______________
Patient Printed Name **Date**