CLAYTON DENTAL OFFICE
THOUSAND ISLANDS CENTER OF DENTAL TECHNOLOGY
SCOTT A. LaCLAIR, D.D.S.

775 Graves Street
Clayton, NY 13624
T 315-686-5142 F 315-686-2310
CLAYTONDENTALOFFICE.COM

I,_____hereby request and authorize
Patient or Guardian Name

_____
Previous Practice or Dentist Name

_____
Street Address

_____ to disclose and provide copies
City-State-Zip Code

of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to:

Clayton Dental Office
PO Box 405
Clayton, New York 13624
315-686-5142

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation 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 the requested information.

Patient Name:_____DOB_____
Patient Name:_____DOB_____
Patient Name:_____DOB_____
Patient Name:_____DOB_____
Patient Name:_____DOB_____
Patient Name:_____DOB_____

Patient/Guardian Signature:_____Date:_____