Records Release/Request Information

I ____ hereby request and authorize
Patient or Guardian Name

____to disclose and provide copies
Practice or Dentist Name

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

Mark J. Gross D.D.S.
Andrew S. Kaplan D.M.D.
11 East 86th Street
New York, NY 10028
(212) 987-7400

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment plans, treatment plans, treatment records, referrals and consultation recommendation and reports, diagnostic models, and other related materials.

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

Signed: ____________________________________ Date ______________
Patient or Guardian