

RELEASE OF RECORDS

I, the undersigned, hereby request the release of dental records, medical records, and relevant radiographs, or copies of such, and request that they be transferred to: Clove Dental, 200 Cleveland Street, Suite C, Muscatine, IA 52761. If digital copies are available, please email to smile@clovedental.com.

I, the undersigned, hereby request and authorize Clove Dental to disclose my clinical treatment records and financial information concerning my care to the following person:

I, the undersigned, hereby request and authorize Clove Dental to disclose and provide copies of any and all clinical treatment records and information concerning my care to the following dental location:

Patient Name:

LAST

FIRST

MI

PREFERRED

Patient's Date of Birth:

If Patient is a minor, name of Parent or Guardian:

Please sign and email to smile@clovedental.com.

Note: there is a risk that information sent in an unencrypted email could be read by a third party.

Signature of Patient or Parent/Guardian:

Response Date: