I ___________________________________ hereby request and authorize

___________________________________ to disclose any and all treatment records concerning my care. These records are to include personal patient information, medical and dental histories, examination records, radiographs, clinical photos, treatment plans, treatment record, referral and consultation recommendations and reports, diagnostic models, and other related material to:

Houston Dental Clinic

109 East Maple Street

P.O. Box 275

Houston, MN 55943

office@houstondentalclinic.com

Signature: ___________________________ Date: _____________________