



FROM THE OFFICE OF DR. LACLAIR

SCOTT LACLAIR, D.D.S. * ROBERT LACLAIR, D.D.S.

Clayton Dental Office
775 Graves Street
Clayton, New York 13624
315-686-5142
www.claytondentaloffice.com

Laclair Family Dental
111 S. Mechanic Street
Carthage, New York 13619
315-493-1184
www.laclairfamilydental.com

*Patient Authorization to Release Confidential Information

I _____ hereby request and authorize
Patient or Guardian Name

_____ to disclose and provide copies
Previous Practice or Dentist Name

Street Address

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.

*Please note: Receipt of your records in advance of your appointment will provide Drs. LaClair familiarity with your dental history and may reduce costs.

Patient/Guardian Signature: _____ Date: _____