



**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: \_\_\_\_\_