Peace Dental Associates, P.C.
35 South 2nd Street
Clarion, PA 16214
814.226.8690

# Records Release Form

Patient Name: _____
Date of Birth: _____

My permission is granted to all providers at Peace Dental Associates, P.C. to disclose to :
_____

Complete information concerning the medical findings and treatment of patient:

_____

For dates of service: _____

I release Peace Dental Associates, P.C. and all of its providers from any laws related to disclosure of confidential or privileged information.

Patient Signature: _____
Address: _____
Witness: _____
Date: _____