James D. Spivey, D.D.S., M.S.

278 Lafayette Road Building E
Portsmouth, NH 03801
Ph: (603) 436-7787
Fax: (603) 430-8597

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I ________________________________ hereby request and authorize

______________________________ to disclose and provide copies of any and all

clinical treatment records and information concerning my care, which is in the possession

of this person or entity to:

Name of person receiving these records: ______________________________

Address: ______________________________

City, State and Zip Code: ______________________________

Telephone No.: ____________________ Fax No.: ____________________

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.

Signed: ____________________________________ Date: ________________
Patient or Guardian