

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:

Hesston Dentistry
353 N. Old Highway 81
P.O. Box 250
Hesston, KS 67062
T: 620.327.2887 | F: 620.327.2078

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 or Guardian Signature

Date