RELEASE FORM

1.) I authorize release to my dental benefits plan administrator and the Canadian Dental Association, information contained in claims submitted electronically.

2.) I authorize Cranston Dental to release dental records to other dental offices that I may be referred or transferred to. I understand that the specific type of information to be disclosed could include a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

This consent is effective until such date as I can cancel this consent or I am no longer a patient at this office. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signature of patient, parent or guardian

_____

Date: _____