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Release of Dental Records

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Date: _____

To: _____
Dentist/Office Name

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Print name of patient Date of Birth

Signature (patient, parent, guardian)

Additional Notes: _____
