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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: \_\_\_\_\_

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