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RECORDS RELEASE AUTHORIZATION

Patient's name:_____

Patient's address:_____

City/State/Zip:_____

I hereby authorize the release of my complete dental records and X-rays to:

Myself_____

Or Doctor/Facility:_____

Doctor's Address:_____

City/State/Zip:_____

Doctor's E-Mail:_____

Doctor's Phone/Fax:_____

Patient or Guardian's Signature:_____

Date:_____