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Record Release Form

Date: _____

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

Name of Doctor: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Telephone: _____

Fax number: _____

E-mail: _____

Date of Birth

Print Name of Patient

Signature (Patient, Parent, Guardian)