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CONSENT TO RELEASE OF DENTAL INFORMATION

Date:_____

Patient name:_____

Address:_____

Contact number:_____

Information requested- by default we send only x-rays; this is all most offices require.

_____

_____

_____

I hereby authorize the release of my DENTAL RECORDS and that they be transferred to the following institution:

To:_____

Address:_____

City:_____

Phone number:_____

Email:_____

_____
Printed name of patient

_____
Signature of patient or guardian