RECORD RELEASE FORM

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

TO: _____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

EMAIL: _____

Records requested: _____

Name of Patient: _____ Date of Birth:_____

Name of Patient: _____ Date of Birth:_____

Name of Patient: _____ Date of Birth:_____

Signature of Parent/Guardian:_____ Date: _____

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