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RECORDS RELEASE REQUEST

Date \_\_\_\_\_

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

Dentist or Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email address \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient (Guardian, if minor)

\_\_\_\_\_  
Print Name