DENTAL RECORDS RELEASE FORM

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PATIENT(S) INFORMATION (Please Print):

Name(s)____
Address____
City____
State____
Zip____
Phone____
Date of Birth(s)____
Social Security Number(s)__________________________________

I hereby request that my dental records be released to:

Dentist's Name____
Address____
City____
State____
Zip____

Reason for Release of Records_______________________________

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BY MY SIGNATURE I AUTHORIZE RELEASE OF MY DENTAL RECORDS:
Signature of Each Patient or Parent(Guardian)

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Date_____________