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Patient Release of Dental Records Form

Patient Name:____
Patient Date of Birth:_________________________________
Today's Date:____

Release my dental information to/from:

Physician's Name:___________________________________
Address:____
City:_____________________ State:________ ZIP:_________
Phone:__________________________ Fax:______________
EMAIL:____

Reason for Release of Records:
____
____
____

Patient/Guardian Signature:___________________________