Authorization To Release Dental Records

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To: _____
(Previous Dentist Name)

Address: _____

Phone: _____ Fax Number: _____

Please release all dental records including x-rays for:

_____
Patient's Name (Last) (First) (Middle Initial)

_____
Date of Birth

_____
Address

_____
Phone

I hereby authorize release of all my dental records and take full responsibility.

_____ _____
Signature/Parent/Guardian Date