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Authorization for Release of Dental Records and X-Rays

Name of Patient:_____

Patient's DOB:_____

Patient's Address:_____

_____

Name of Previous Dentist:_____

Practice Phone Number:_____

I, _____, hereby authorize the release of dental records or knowledge concerning my dental health to:

Full Name of Doctor:_____

Practice Telephone Number:_____

Patient/ Guardian Signature:_____

Date:_____