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RELEASE OF DENTAL RECORDS

If you wish to have you dental records forwarded to another dental office, please fill out the sections below and mail the form to our office. We will forward your records as soon as this form is returned to us. PLEASE PRINT CLEARLY.

DATE:_____

YOUR NAME: _____

ADDRESS: _____

CITY, STATE, ZIP CODE_____

NAME OF DENTIST: _____

ADDRESS: _____

_____

_____

Your Signature:_____

Today's Date:_____

Thank you.

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