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REQUEST AND RELEASE OF DENTAL RECORD

This form is to authorize the release of my dental records.

Patient's Name: _____

Date of Birth: _____

I give permission to the following dental office to release my records:

Dentist: _____

Phone: _____

I authorize my xrays and records be emailed to:

xrays@drjimdentist.com

Patient's Signature: _____

Date: _____