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CONSENT FROM PATIENT TO RELEASE DENTAL RECORDS

Date:_____

TO: (Current Dentist)_____

Patient Name/Names:_____

Date of Birth (Person requesting)_____ SSN: _____

Release To: _____

_____

_____

I request and authorize the above named health care provider to release my dental records to the person and/or organization named in this request.

Patient Signature: _____

Date:_____