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REQUEST FOR RELEASE OF RECORDS

I, _____, hereby request and give my permission to
DR. _____, to provide DR. _____
with any and all information he/she requests with respect to the dental
treatment of the above named patient.

I agree to pay the cost of duplicating any records. A facsimile or photograph of
this release will be as effective and valid as the original.

Signed: _____
(Patient)

Signed: _____
(Parent, legal guardian or custodian of the patient, if a minor)

Address: _____

Date signed: _____