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Authorization to release Dental Records

I hereby request that a summary of dental care and / or duplicate xrays be sent to:

On the following patient(s):

Birthdate: _____
Birthdate: _____
Birthdate: _____
Birthdate: _____
Birthdate: _____

Reason(s) for this authorization:

- Older, moving on to adult dentist
- Change of insurance, required to see a preferred provider
- Other _____

Date: _____
Patient / Parent / Legal Guardian

Additional comments:

