

ART OF THE SMILES

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Dental Records Release Form

I, _____, authorize and request the release of all dental records and x-rays to:
_____ for the purpose of continuing dental care. All authorizations must be signed by the patient or by an authorized person in case of a minor or when the patient is physically or mentally incompetent.

Patient Name: _____

Date of Birth: _____

Signature: _____ Date: _____