Authorization of Release of Dental Records

I, _____, hereby request and grant permission to _____ to release a copy of my complete records, including x-rays and laboratory reports to the dentist of my choice named below. I acknowledge that I may revoke this authorization, with written notice, at any time.

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Patient/Parent, Guardian (Print)_____

DOB_____

Patient/ Guardian Signature_____

Date_____

Witness Signature_____ Date_____