Pediatric Dentistry & Family Orthodontics

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RECORDS RELEASE REQUEST

TO:_____
(Doctor/Hospital)

ADDRESS_____

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I hereby authorize the release of my dental records and request that they be transferred to:

PEDIATRIC DENTISTRY & FAMILY ORTHODONTICS
8016 EAST GENESEE ST.
FAYETTEVILLE, NY 13066
Phone: 315-637-6961
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_____ DOB:_____
(Print Name of Patient)

_____ Date _____
Patients/Parents signature (Parent must sign if under age 18)