Pediatric Dentistry & Family Orthodontics

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REQUEST FOR RELEASE OF RECORDS

Date_____

I hereby authorized the release of all records and x-rays pertaining to:

_____.
Patient's name

Reason for leaving: _____

_____.

Please send to:

_____

_____

_____

Thank you for your assistance in this matter.

_____
Parent or Guardian's Signature

_____
Witness