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TO: OFFICE OF_____

City_____ State_____

Telephone:_____

FAX:_____

RECORD RELEASE AUTHORIZATION

I do hereby request copy release of my Dental Radiographs (X-rays) and any pertinent Dental Records for the office listed above, to be sent to the office of Dr. Carol Schaffer, either at the above email or mailing address, on this date, _____, 20_____.

Thank You!

_____ _____

PRINT Patient Name Patient Date of Birth

_____

Patient SIGNATURE