BANNERWOOD FAMILY & COSMETIC DENTISTRY
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RECORDS RELEASE FORM

Patient Name_____

Address_____

_____

Phone_____

I have authorized _____ to disclose x-rays and records relevant to dental treatment, or copies of such, to the doctor's office indicated below.

I release _____ from any laws related to disclosure of confidential or privileged information.

_____ _____

Signature of Patient or Guardian Date

Where records are to be sent:

Name_____

Address_____

_____

Phone_____