DENTAL RECORDS RELEASE FORM

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Patient's name: _____

Patient's date of birth: _____

To whom it may concern,

I hereby authorize you to release any information or records regarding my dental treatment to Dr. Denise C. Gay's office at the above email/address. Please send any current x-rays or any information that would be helpful in my dental treatment.

Thank you for your cooperation.

_____ _____

Patient, Parent or Guardian signature Date

Digital Image Information: Please send digital x-rays in JPEG FORM.