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## Dental Records Release

I, \_\_\_\_\_, authorize the release of my dental x-rays/records  
and request that they be transferred to:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Email (if applicable)

\_\_\_\_\_  
(Patient or Guardian Signature)

\_\_\_\_\_  
Date