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Date: \_\_\_\_\_

Please release my dental records including current radiographs and pertinent clinical notes to the address above.

Patient name: \_\_\_\_\_

Patient date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Street Address

\_\_\_\_\_  
City State Zip

Signature: \_\_\_\_\_

Thank you!