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RECORD RELEASE AUTHORIZATION

TO:_____ FAX: _____

I, _____, hereby grant permission to and request release of information from the above addressee related to history, status of treatment, and copies of dental records, **Radiographs**, and/or any test results or periodontal charting for the following patient(s):

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

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