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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

I hereby authorize the doctor and staff of ***Patrick L. Dobash, D.D.S., P.C.*** to release records (including x-rays) concerning the dental health of _____ to:

Dr./Practice Name _____

Street Address _____

City, State, Zip _____

Phone No.: _____

Fax No.: _____

Email: _____

Signed: _____
(patient or guardian name)

Printed name: _____
(patient or guardian name)

Date: _____