DENTAL RECORDS RELEASE

PATIENT NAME: ____

DATE OF BIRTH: _______________ SOCIAL SECURITY ___________________

I REQUEST MY DENTAL RECORDS BE RELEASED TO THE FOLLOWING DENTIST:

DR: _____________________________________

ADDRESS: ________________________________

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PHONE: _________________________________

By signing below, you are authorizing Dr. W. Lee Young, Jr., to turn over your dental records to the dentist you have designated above. If you have more than one family member in our practice, each adult family member should sign individual releases.

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PATIENT OR GUARDIAN (specify relationship) DATE