Request for Release of Records

Date: ________________________

I hereby authorize the release of my dental records or copies of such and request that they are transferred to:

To (Doctor or Hospital): ____

Address: ____

City: ______________________________ State: __________ Zip: ___________

Email: _____________________________ Phone Number: __________________

Patient Name: ____

Date of Records: ____

Patient's Signature:____

Mission Hills Dentistry

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