Metro Dentalcare

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Request for Release of Records

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

To: (Clinic Name)____

Email Address: ____

Mailing Address____

City__________________________________ State__________ Zip________________

Today's Date: ____

Patient Name:____

Patient Date of Birth:____

Patient Signature: ____

Guardian Name if signing for minor: ____