RECORDS / X-RAY RELEASE REQUEST

Date: _____

Faxed or sent to Dr. _____

I authorize the release of dental records/x-rays relevant to dental treatment for myself and/or any family members listed below to be transferred to:

Doctors Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Name of Patient (s):

_____

_____

_____

_____

_____

_____

2800 Niles Road, Saint Joseph, MI 49085

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