Request of Records

I authorize the release of all current x-rays, dental records, and relevant correspondence on behalf of myself and those listed below to be released and sent to Kelly Family & Cosmetic Dentistry from the dental office below:

Dental Practice Name: ______________________________

Address: ______________________________

Phone: ______________________________

Email: ______________________________

Name/DOB: ______________________________

Name/DOB: ______________________________

Name/DOB: ______________________________

Name/DOB: ______________________________

Patient/Parent/Guardian Sigiture: ______________________________

Date: ______________________________

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