

All Seasons Dental  
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**Patient Authorization for Release of Dental Records**

I, the undersigned, \_\_\_\_\_ (print name), consent to the release of my dental records and/or radiographs including related clinical notes and treatment plans (if applicable) To:

Name of Dental Office and Address:

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Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient(s) name and date(s) of birth.

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