AUTHORIZATION FOR TRANSFER

OF DENTAL RECORDS / INFORMATION

SEND TO ● REQUEST FROM (Circle one)

PLEASE CANCEL ALL UPCOMING APPOINTMENTS NO YES (Circle one)

Reason for leaving: _____

*Authorization for release / transfer of records:

X Date: _____

*(Signature of parent or guardian required if patient is under the legal age of adulthood.)

*** This authorization will remain in effect until which time as the patient (if of legal age) or the parent / legal guardian request otherwise. ****

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