Upstate Family Dental
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RECORDS RELEASE FORM

I, _____, request the release of dental records relevant to dental treatment, or copies of such, and request they be transferred to/from:

_____

_____

_____

Patient Name: _____Birth Date: _____
Patient Name: _____Birth Date: _____
Patient Name: _____Birth Date: _____

( ) Current Radiographs
( ) Chart
( ) Treatment Records
( ) Other: _____

_____

_____

Signature (parent/guardian): _____

Date: _____