

Buttermilk Family & Cosmetic Dentistry
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Request for Release of Records

Date: _____

I hereby authorize the release of my dental records or copies of such and request that they are transferred to:

To (Doctor or Hospital): / SELF _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Name: _____

Date of Records: _____

Patient's Signature: _____

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DENTAL CARE
Personal attention | Professional excellence