Records Release Authorization

I, _____ authorize

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Office (610)252-0646
Fax (610)252-2128
Email 1208ARS@gmail.com

To release copies of my dental X-rays, and a brief summary of my past treatment to:

Dentist: _____

Address: _____

City, State, Zip: _____

Phone number: _____

Fax: _____

Email: _____

Signature_____ Date_____

Additional family members: _____

_____

_____

_____

Thank You.