REQUEST FOR RELEASE OF RECORDS

I hereby release all dental records including radiographs and daily treatment notes from the office of Dr. ____________________________to Dr. _______________________
I also release you from all legal responsibility or liability that may arise from this authorization.

Please send my records to:

Crestview Dental
41 East Ave
Westerly, RI 02891
401-596-0319
Crestviewdental@yahoo.com

Signature ____
Patient or Person Authorized to Consent for Patient

Patient's Name____

Address: ____

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Date __________________________________