

DR. BOB MALEY, D.D.S.

CONFIDENTIAL

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RECORD RELEASE REQUEST

Previous Dental Office Information

Name: _____

Phone Number: _____

Patient(s) Name: _____

Date of Birth: _____

Patient/Guardian Signature: _____

Date: _____

I am requesting and authorizing the release of current dental x-rays and records to be transferred to the following address:

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