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Consent from Patient for Release of Dental Information & Records

Instructions:

Please complete this form and mail or fax to your previous dentist.

I hereby authorize you to send a copy of the dental records, including all progress notes and radiographs for: _____ (Patient's name)

from the office of: _____

To the office of Daniel K. Dube, DDS, PA at the above address. I release you from all legal responsibility or liability that may arise from this authorization.

Thank you.

Signature of Patient, Parent or Legal Guardian

Date