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## RECORDS RELEASE REQUEST

I hereby authorize the release of my dental records, x-rays  
and any other pertinent information and request they be  
transferred to:

To \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Il \_\_\_\_\_

Name of Patient(s): \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_