Hulse Dental

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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I,_____(print name), hereby request the disclosure of information from my dental records on file with your office.

Patient Name:_____

Date of Birth: _____

____ For transfer of records **TO** Hulse Dental

Previous Office/Doctor:_____

____ For transfer of records **FROM** Hulse Dental

Transfer to:_____

_____

Patient/Guardian Signature Date