Ideal Smiles Family & Cosmetic Dentistry

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Authorization for release of Dental Records & X-Rays

I, _____, hereby authorize the doctors and staff of

_____ to access and release my records or any requested information concerning my dental health to:

I specifically request that you release copies of:

_____ All X-Rays

_____ Other (Please specify) _____

_____

Signature _____ Date: _____