

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:** _____

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