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## Patient Records Release

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

I, \_\_\_\_\_, Date of Birth of \_\_\_\_\_ request  
copies of my dental x-rays be sent to: \_\_\_\_\_.

Any correspondence sent via e-mail will be transmitted over a non-encrypted  
non-secure line.

\_\_\_\_\_

\_\_\_\_\_

Patient's Name

Patient's Signature