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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ authorize and request

To release:

___ All dental/medical records

___ All current radiographs



___ Regarding my care to: (or)

___ Regarding _____'s care to:

(Minor/Dependent)

I expressly release from liability the above named person and/or entity from any and all liability arising from compliance with this request and disclosure of the requested information. This release is valid for ninety days.

Signed, _____ Date: _____

(Patient or Guardian)