Dental Associate Group, LLC
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Phone # 203-374-0000 Fax # 203-374-0002
Email: info@dentalassociategroup.com
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DENTAL / X-RAYS RELEASE REQUEST

Date______________________

To____

Address____

City________________________________**State**_______________**Zip**___________________________

I authorize the release of dental records/ x-rays relevant to dental treatment, or copies of such, and request that they be transferred to the above address.

______________________________________ ______________________________________

Name of patient **Signature of patient /parent or guardian**