

Release of Records

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

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize you to transfer or make available to:

 (Please print full name)

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Records, x-rays, and reports relating to my case.

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Signature of Patient (or parent)

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Witness

**Pamela K. McClain, DDS** Diplomates, American Board of Periodontology **Rachel A. Schallhorn, DDS, MS**

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