

Dental Records Release Form

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I authorize and grant full permission for all patient chart information including patient history, radiographs, and correspondence with dental specialists for the parties listed below to be released and forwarded to:

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Marshall, Minnesota 56258
Email: infoscheduling@michaelrthomasdds.com

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

Signature: _____ Date: _____