



WHITE HOUSE DENTAL

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Records Release Request

Patient Name: _____
Last First M. Date of Birth

Forward records to

Office Name: _____

Address: _____

Office phone # _____ Office Fax: _____

Forward records from

Office name: _____

Address: _____

Office Phone # _____ Office Fax: _____

I hereby give my permission for release of any and all Medical and/or Dental records pertaining to me or immediate members of my family to the office listed above.

Additional Comments: _____

Signature: _____ Date: _____