

Asheville Family Dentistry

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****PLEASE SEND THIS FORM TO YOUR PREVIOUS DENTIST****

REQUEST FOR RELEASE OF DENTAL RECORDS AND/OR X-RAYS

Patient Name: _____

Date of Birth: _____

Patient's Address: _____

I request that my dental records and/or x-rays be released to:

Doctor: _____

Address: _____

Patient's Signature: _____

Date _____

(If guardian to patient-state relationship _____)

Office Representative _____

NOTES: _____
