Uehara Family Cosmetic Dentistry
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AUTHORIZATION TO RELEASE DENTAL RECORDS

Date _____

I, _____,

authorize Uehara Family Cosmetic Dentistry to release all dental records to:

_____
Name of Doctor

_____
Doctor's email address

_____
Address

_____
City, State, Zip Code

I release Uehara Family Cosmetic Dentistry from all liability that may result from the release of these dental records.

_____
Signature of patient