

RECORD RELEASE FORM FOR DENTAL INFORMATION

I, _____, DOB _____ do hereby give permission to
(patient name) (Date of Birth)

Dr. Ted Fields Oral & Maxillofacial Surgery to send copies of my dental images and/or dental implant information to the following provider:

Name: _____

Address: _____

City, State, Zip code: _____

Phone Number: _____

Email Address: _____

Signature of Patient Name or Patient Parent/Guardian

Date:

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