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# Release of Records Form

**I, _____**
(print name)

**of _____**
_____
_____
(address)

**give consent to**
_____
_____
_____
(details of previous dentist)

**to forward the entire contents of my dental/medical records and radiographs to r*f*g Dentistry.**

**Signature of Patient: _____**

**Date: _____**