Dental Record Release Authorization

Please fill out this form completely.

Name: ______________________________ D.O.B. ______________

I authorize:

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To release to:

Dr. Rebecca Taylor, D.D.S./Green City Dental and/or associates
8405 196th SW
Edmonds, WA 98026

[ ] All of my dental records

[ ] My records regarding specific conditions or time period indicated: ______________

____

Signature: ____

Parent/Legal Guardian: ___________________________________ Date: ___________

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