

Hulse Dental
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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I, _____ (print name), hereby request the disclosure of information from my dental records on file with your office.

Patient Name: _____

Date of Birth: _____

_____ For transfer of records **TO** Hulse Dental

Previous Office/Doctor: _____

_____ For transfer of records **FROM** Hulse Dental

Transfer to: _____

Patient/Guardian Signature

Date