Permission to Transfer Patient Records

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Patient Name(s): 1. _____ 2. _____

3. _____ 4. _____

Please send copies of patient records to:

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I hereby give permission for Milford Pediatric Dentistry, Inc. to release copies of the dental record(s), including charting notes and radiographs, for the above-named patient(s). Please send the copies only to the entities identified above.

Name of authorized guardian: _____ (please print)

Signature of authorized guardian: _____ Date: _____