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DUPLICATION OF RECORDS & RELEASE REQUEST FORM

Date of Request:	Team Member taking request:	
Patient Name:		
Send Records to (must be a licensed dentist):		
Address for licensed dentist:		
City	State	Zip
Date Needed By:	HIPPA Release Form Signed: Y N	
Records Duplicated By:	Records Mailed By:	
Patient Signature:		

*\*Grey areas are for office use only.*