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21 TOTMAN STREET QUINCY, MASSACHUSETTS 02169, USA P: 617 834 4573

Records Release

I hereby authorize and request you to release to:	
The complete dental records, including concerning the treatment of:	ng all x-rays, in your possession
Patient(s) Name	D.O.B.
Reason for transfer:	
Signature:	
Relationship:	
Date:	
Section 1	

