AUSTIN
ORTHODONTICS

Patient Authority to Release Dental Records

I, _____ hereby authorise

_____[doctor's name/practice name] of

_____ [address]

to release my records or copies thereof (including radiographs and photographs where applicable)

and those of my following dependants:

_____

_____

_____

and to provide such records to Austin Orthodontics

Full name: _____

Date of birth: _____

Address: _____

_____

_____

Phone: _____

Signed: _____ Date:_____

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