Glen Lake Family Dentistry

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Patient(s) under guarantor that should be sent (please print):

Patients Name: _____DOB_____

Patients Name: _____DOB_____

Patients Name: _____DOB_____

Patients Name: _____DOB_____

Patients Address: _____

City_____ State: _____ Zip Code: _____

I hereby authorize release of my dental records to:

info@glenlakefamilydentistry.com

Signature of Patient/Guardian_____

Date _____

releaseofrecords