COASTAL CONNECTICUT DENTISTRY

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PATIENT RECORD RELEASE REQUEST

I hereby give my permission to **Doctor** _____

Practice Name _____

Practice Address _____

Phone Number: _____

Fax Number: _____

To release **(email)** a copy of my dental records and X-rays:

COASTAL CONNECTICUT DENTISTRY

EMAIL- office@coastalctdental.com

_____/_____/_____

Patient's Name **Date of Birth**

_____

Patient's Signature

Date_____

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