RECORDS RELEASE REQUEST

Date _____

To _____ (DOCTOR)

Address _____

City _____ State _____ Zip _____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

MICHAEL CHRISTIANSEN, D.M.D.
P.O. Box 331 — Jamison, PA 18929
Telephone: (215) 343-8162

_____ Print name of patient

_____ Signature (patient, parent or guardian)

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