

DENTAL DEPOT
FAMILY DENTISTRY

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Records Release

Date: _____

My permission is granted to Dr. _____
(Previous Dentist Name)

To disclose to Dr. Kevin P. Williamson D.D.S.
Dr. Jeffrey A. Hauger D.D.S.
2 East 5th St / PO Box 686
Morris, MN 56267

Complete information concerning the dental findings and treatment of:

(Patient Name) (DOB)

Any FMX or Pan no matter the year and most recent BW no matter the date

I release Dr. _____
(Previous Dentist Name)

Previous Dental Office: _____

Phone/Fax Number: _____

From any laws related to disclosure of confidential or privileged information.

Patient Signature _____