

AUTHORIZATION TO RELEASE PATIENT RECORDS

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I, \_\_\_\_\_, hereby authorize the release of dental records to Dr. Michael Bliss from

\_\_\_\_\_  
Name of Dentist or Clinic

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient