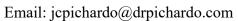


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Record Release Request

| | | Date: | |
|------------------|--|---|--|
| To Dr. Pichardo: | | | |
| I, | Date of birth ords relevant to dental treatment, d to: (dentist/myself): | authorize the release of or copies of such, and request | |
| | | | |
| | | | |
| | | | |
| Patient Name | | atient/Guardian Signature | |