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PATIENT CONSENT FORM
RELEASE RECORDS AND RADIOGRAPHS

I hereby request, and consent to, the release of my records and radiographs to the office of: Cooke, Richardson & Overstreet, D.D.S., P.C.

Patient's Name: _____

Address: _____

Phone #: _____

From the office of: _____

Address: _____

Phone #: _____

Email: _____

Thank you,

Printed name of patient

Signature of patient or legal guardian

Date