

# Bomstad Dental

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I, \_\_\_\_\_, authorize the release of my dental records.

**Please release my records to:**

Name of Clinic: \_\_\_\_\_

Clinic's Phone #: \_\_\_\_\_

Clinic's Email: \_\_\_\_\_

Other: \_\_\_\_\_

**Please also release the records of the following patients:**

Patient Name	Patient DOB

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date