Ina Dentistry
James W. Symonds, DDS

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RECORD RELEASE

I, ____, do hereby authorize that my dental
(Patient Name)
records be furnished to:

____

____

____

____

Covering the period of ____ to
(month, day, year)

____. I release you from all legal
(month, day, year)

responsibility or liability that may arise from this authorization.

____ ________________________
Patient Signature Date

____ ________________________
Witness Signature Date