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RECORDS RELEASE

I authorize Dr. Dimitri Ganim to release a copy of

_____records to:
PRINT PATIENTS NAME

Name _____
Address _____
City _____State _____Zip _____

_____ _____
PATIENTS SIGNATURE DATE

I am requesting the release of these records because:

____ I am seeking a consultation with another dentist/specialist

____ I am/have relocated

____ Insurance considerations

____ I am unhappy with_____
_____