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## RECORDS RELEASE AUTHORITY

Date: \_\_\_\_\_

I hereby authorize the office of Dr. Mark Allen to release my dental records/xrays. I request they be transferred to:

Attention: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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