

# Monticello Family Dentistry

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## Consent Form for Release of Information

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I would like my Dental X-rays/Records sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REASON FOR LEAVING \_\_\_\_\_

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

Date