Release of Records

Date:_____

I hereby authorize the office of _____
To release my dental records. The records will be transferred to:

Blaire E. Warren, DDS, PLLC
142 Doctors Drive
Boone, NC 28607

warren.dentistry.boone@gmail.com

Patient Name:_____
(please print)

Patient or Guardian Signature:_____

Date:_____

Type of records sent:_____

_____

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