



**BOWLING & DUNN
FAMILY DENTISTRY**

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I hereby authorize the release of my dental x-rays and records, be transferred as indicated below:

Patient's Name: _____

Patient's DOB: _____

Patient's Name: _____

Patient's DOB: _____

Patient's Name: _____

Patient's DOB: _____

Patient's Name: _____

Patient's DOB: _____

Patient's Name: _____

Patient's DOB: _____

Send records to: _____

Authorized signature: _____

Date: _____

**Email: info@bowlingdunnfamilydentistry.com
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