Shore Endodontics

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Tel: 732-893-8600
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AUTHORIZATION TO TRANSFER RECORDS

Date: _____

From: _____ (patient)

I hereby authorize you to transfer or make available, to the doctor listed below, all x-rays and/or all records related to the dental treatment received at your office.

_____

Doctors Name:

_____

Address:

_____

_____

_____

Phone: _____
Fax: _____
Email: _____

Signed: _____ Dated: _____