oconee dental associates

Date: _____

I authorize that the release of my dental records and x-rays are transferred to:

_____

_____

_____

_____

_____
(Printed Name)

_____
(Signature)

_____
(Date of Birth)

Other patients/family members requesting transfer:

Name_____
DOB: _____

Name_____
DOB: _____

Name_____
DOB: _____

Please email x-rays to: oconeedent@bellsouth.net

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