Middletown Valley Dentistry
Home of Snoring Isn't Sexy & IhatemyCPAP.com

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Record Release Form

Date:___/___/_____

To:_____

Purpose: (Circle one)

Insurance / Referral to Specialist / Move / Transfer to another PCP
Other:_____

I hereby authorize release of my medical records or copies of such and request that they be transferred to:

_____

Name of Patient:_____

Records may be under the name of:_____

Signature of Patient:_____

Witness:_____