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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: ____

I, the patient or legal guardian of the named above, request and authorize Kimberly A. Chapman, DDS to release my health care information to:

Name: ____
Address: ____
City, State, Zip: ____

This request and authorization applies to:

________ X-Rays

________ Health Care information to the following treatment, condition, or dates of treatment: _________________

________ Other ____

____
Signature of Patient Date