Records Release Form

I _____ of _____
Patient name printed Patient address

Authorize _____to release my dental records and x-rays
Previous dentist/practice name

To: iSmile Dental Associates of Peabody
210 Andover Street
Peabody, MA. 01960

Please mail these records out as soon as possible. If there will be any delay, please contact me.

_____
Patient signature Date

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