

MICHAEL BEIER, D.M.D.

DENTIST

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REQUEST FOR RELEASE OF DENTAL INFORMATION

I consent to the release of any dental information and/or dental radiographs from:

Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_