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Request for Dental Records

Your Details

I, (name) _____

of (address) _____

give consent to Integrated Dental Health to release my dental records to me directly.

This includes relevant reports, x-rays, etc. I understand that I will not be permitted to remove the contents of my dental records from the premises of the dental practice, nor will I be permitted to alter or erase information contained within these dental records.

Signed (your signature): _____

Date of Birth: _____

Today's Date: _____