

Luciano D. Marini, D.M.D.

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REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and x-rays and we hereby, request that you release the following patient's records:

Patient's Name : _____

DOB : _____

Address :

Signature _____

Guardian (if applicable)

Date

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.



Luciano D. Marini, D.M.D.

Date

We thank you in advance for help and cooperation in this matter.