

# VALLEY DENTAL GROUP

## RECORDS RELEASE AUTHORIZATION

DATE: \_\_\_\_\_

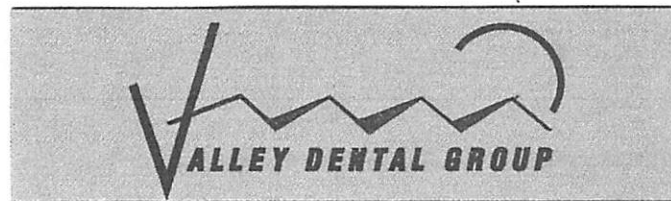
To Whom It may Concern:

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

I authorize the release of my x-rays to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient



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