Records Release Authorization

I give permission to: ____

____

____

to release my records/xrays to:

Coventry Family Dental

903 Tiogue Ave Coventry, RI 02816

(p) 401-821-5864 **(f)** 401-821-3245

Email: info@smilingri.com

____ / ______________

Patient's name (please print) **Date of Birth**

____ / ______________

Patient's Signature (Parent/Guardian if patient is a Minor) **Date**

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