Records Release Authorization

Patient's Signature (Parent/Guardian if)		/
n		
Patient's name (please print)		Date of Birth
		1
Email: <u>info@smilingri.com</u>		
(p) 401-821-5864 (f) 401-821-324	1 5	
903 Tiogue Ave Coventry, RI 0281	6	
Coventry Family Dental		
release my records/xrays to:		
give permission to:		

Records Release Authorization

D .:	t/Guardian if patient is a Minor)	Date
э		/
Patient's name (please pri	nt)	Date of Birth
		/
Email: <u>info@s</u> ı	milingri.com	
(p) 401-821-5864 (
	/	
903 Tiogue Ave Cov	entry, RI 02816	
Coventry Famil	y Dental	
o release my records/xrays t	: 0:	
give permission to:		