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I grant permission for Concept Dentistry to disclose x-rays, periodontal charting and treatment findings to the office of/or from the office of:

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

 Name

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 Address

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 Phone Number

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 Email

I release Concept Dentistry from any laws related to disclosure of confidential information.

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Print Patient Name Patient’s Date of Birth

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Signature Date