Conte Dental Associates
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Bonita Springs, Florida 34135
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www.contedental.com

Dental Records Release

Patient name to transfer: _____

Date of birth: _____ Phone #: _____

I hereby give you permission to release any information and records regarding my dental health to:

Dentist or Practice Name: _____

Address: _____

City/ State/ Zip: _____

Phone number: _____

Email address: _____

Thank you for your cooperation.

_____ _____

(Patient or guardian name) (Date)