

# Records Release Form

I \_\_\_\_\_, give permission to Dr. \_\_\_\_\_ to release to  
Dr. Keith Konvalinka, DDS information about my health status, x-rays and dental records.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_

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