

# Kingsgate Dental Clinic

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## Release of Records

I, \_\_\_\_\_ hereby authorize you to release a copy of my records to \_\_\_\_\_ at this address: \_\_\_\_\_

Please also release the records of my dependent \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Guardian