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Authorization to Release Protected Health Information

I, ____________________________________, date of birth ____________________________, authorize Dr. Anna V. O'Keefe and Dr. John Poirier and any associated dentists or dental practices to release any and all dental information to (please write information below of provider to whom we will send the records):

NAME: ____

ADDRESS: ____

____

EMAIL: ____

TELEPHONE: ____

This release includes but is not limited to any clinical notes, images and x-rays.

_______________________________________ ___________________________

Signature Date

____

Printed Name