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67 George Street  
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## Release of Records

To: \_\_\_\_\_

Fax/Email: \_\_\_\_\_

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

D.O.B. \_\_\_\_\_

I, \_\_\_\_\_ authorize the release of my dental records to George Street Dental.  
Please forward any radiographs taken within the last 2 years.

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

Thank you,

**Alycia Cosentino**  
*Office Administrator for Dr. Dilpreet Sidhu, DDS*