LANCASTER SMILES

Dr Michael E. Funk DMD
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Authorization for Release of Dental Records

Patient Name _____ Date of Birth ___/___/_____

I hereby authorize the release of all recent dental radiographs to Lancaster Smiles Family and Cosmetic Dentistry.

Patient or Legal Guardian Signature: _____Date: _____

To: _____

Fax: _____

Please Email radiographs to:

Dr. Michael E. Funk

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