Gorgeous DENTAL SMILE
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Patient name:_____ Date:_____

I herby authorize Dr. Silvestre, D.D.S. to release the following information to:

Name/Doctor: _____
E-mail Address: _____
Telephone: _____

Or E-mailed to me the patient at :_____

A. X-Rays: Bitewings or Periapical if taken within one year. FMX less than 5 years
B. Patient History _____
C. Other _____

Please sign below

Patient signature: _____

Date: _____