Records Release Request

To: ____

Address____________________________________

City_________________________ State_________ Zip Code__________________

I hereby authorize the release of my current x-rays and any other requested information to:

Serenity Family Dentistry
Dr. Kathleen O'Connor
3650 Murrell Road Suite 124
Rockledge, Fl. 32955
321.639.7400
SerenityDentistryRockledge@gmail.com

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Patient's Name Date of Birth

____ ______________________

Patient's Signature Date