SOLOMON FAMILY DENTISTRY

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RELEASE OF RECORDS

I,_____(D.O.B.____/____/_____), request that you send my dental records and/or x-rays to Solomon Family Dentistry.

The requested information may be emailed to solomondentistry@gmail.com or if no access, please mail to 1971 North Main Street, Summerville, SC 29483.

Other family members are:_____

Signature of Patient/Guardian_____Date:_____/_____/_____