**MEDICAL RECORDS RELEASE FORM**

I,                                                               , (Print Your Name) hereby authorize you to release any and all **RECORDS, *including CLINICAL NOTES and X-RAYS*** pertaining to dental care for:

TO: Vincent Fuschino, DDS

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

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

Date of Birth: ­­­\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_