Request for Duplication of Orthodontic Records

Patient

Name_____

Address_____

City, State Zip_____

Signature_____

Date_____

Authorized Representative

Name_____

Relationship to Patient_____

Signature_____

Date_____

The above referenced patient and/or representative has authorized this office to request duplications of their orthodontic records. Please mail the records to our office at your earliest convenience.

Sincerely,

Neil Gorin, D.D.S.

Neil Gorin, D.D.S.
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