DENTAL ARTS GROUP
1136 Hartford Avenue • Johnston, RI 02919

Records Release Authorization

Date: _____

Patient Name: _____

Patient Address: _____

Reason for leaving: _____

Patient/Parent Signature: _____

All patient records are subject to a $35.00 duplication fee to cover any associated costs and/or labor.

If requesting records to be mailed or emailed to another dental office or address, please list:

Forwarding address:

_____

_____

_____

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