LYNSEY LINDSTROM, DDS

Authorization to Release Records
To Palmer Dental Center

Records to be released from

Dentist/ Dental Office Name _____

Address _____

Phone _____ Fax _____

Records Requested

☐ Pano ☐ Full Mouth X-Rays ☐ Bitewings ☐ Records

Patient Name(s) _____ Date of Birth _____

_____ Date of Birth _____

Patient/ Parent Signature _____ Date _____

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