Eagle Summit Dental Group Sanders, Fuller, Land & Land

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please email digital images to: msdental@mtaonline.net

Patient's Name	DOB
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I, Group to request my previous de	, authorize Eagle Summit Dental ental records from:
I, Group to forward my dental reco 	, request Eagle Summit Dental ords to:
Patient's Signature	 Date