New Town Dental Arts℠
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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above named dentist(s) to provide any insurance company (ies) , claim administrator, consulting health care professional and/or referring specialist, information concerning health care, dental care, advice, treatment or supplies provided.

This release is valid and effective until withdrawn in writing by me.

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Family Signature (Patient and/or Guardian)

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Family Signature (patient or authorized guardian)

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Date