

STAR DENTAL LLC
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EAST HAVEN, CT. 06512
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I, _____ am requesting dental/medical records and/or x-rays to be released to:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

Please forward requested information to the above listed name in a timely manner.

Thank you in advance for your cooperation.

Print Name

Signature

Date

As parent/guardian I am also requesting dental/medical records and x-rays for the following family members:

Print Name

Print Name

Print Name