Ben Daniel DMD, PA
Family and Cosmetic Dentistry

RECORDS RELEASE REQUEST

To: ____

Address: ____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

Ben Daniel DMD, PA
Family and Cosmetic Dentistry
2098-A Woodruff Road
Greenville, SC 29607

______________________________	______________________________
Print name of patient	Signature (patient, parent or guardian)

2098–A Woodruff Road • Greenville, SC 29607
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