| DATE:  |  |
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| DATIENT NAME(C).   |  |
| PATIENT NAME(S):   |  |
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| l,   |  |
| authorize release of my dental records including x-rays to Island View |  |
| Dental, Dr. Lofgreen, Dr. Kearns, and Dr. Serbousek.                   |  |
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| Dr. Lorgreen, Dr. Kearns, and Dr. Serbousek.  Dr                       |  |
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