RECORDS RELEASE REQUEST

To ______________________________ Office telephone #____________________
(Previous Dentist)

Address ____

City ____

I hereby authorize the release of my dental records or copies of such and request that they are transferred to:

EDWARD M. ORGON, DDS
5707 Marconi Avenue, Suite B
Carmichael, Ca. 95608
(916) 973-0156

Email: eorgondds@comcast.net
*please notify our office after email is sent.

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Name of Patient — Phone

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Patient's Signature — Date