

Date: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to  
send any pertinent dental records of:

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Patient's Last Name	First	Initial	Maiden
Date of Birth: _____			
Address: _____		Phone: _____	

TO:

Halsted Dental Aesthetics  
2001 N. Halsted Suite 202  
Chicago, IL 60614  
(312) 266-0044

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Signature of Patient/Legal Representative

