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TO \_\_\_\_\_

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RE \_\_\_\_\_

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BIRTHDATE \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

The above name patient has authorized release of their records to our office.  
Please forward all pertinent information.

Thanking you in advance for your assistance.

Jeanne L. Fourrier, D.D.S., M.H.S.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date