

DRS. BRODERICK, DUSEK AND DELEON ORTHODONTICS

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RELEASE OF RECORDS

I _____, hereby request and give permission to
Dr. _____ to provide Drs. Broderick, Dusek & DeLeon Orthodontics copies of all
orthodontic records with respect to the orthodontic care of _____.

Such records may include, but not limited to medical care, illness or injury, dental and orthodontic
history, medical history, financial history, consultation, prescriptions, X-rays and models.

I agree to pay the cost of duplication of such records.

Signed _____
(Patient or Parent, Legal Guardian or Custodian of Patient if Patient is a Minor)

Print Signature: _____

Address: _____

Signed: _____ Dated: _____

