Starley Family Dentistry
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RELEASE OF RECORDS FROM STARLEY FAMILY DENTISTRY

Patient Name:

Last First MI

Preferred Name

I hereby authorize the release of my dental records from Dr. Matt Starley
To Dr.:

Mailing Address / City / State / Zip

Phone Number: Fax Number: Email:

For the following member(s) of my family:

*****

☐ I hereby release Dr. Matt Starley from any liability related to disclosure of confidential privileged information.

Patient/Guardian Signature:

Response Date: