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I hereby authorize the release of my records for any treatment or Examination/Xrays rendered to me during the period of my treatment of dental care to Dr. Ronald Wygonik, D.D.S.

Name of Patient(s): _____

Birthdate(s): _____

Previous Dentist Name/Address:_____

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____