Infinity Dental Arts
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I, _____ hereby grant permission to
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(Print Doctor's Name, Facility Name or Hospital)

To release information related to my health history, status, and treatment, and copies of my health record, dental records X-rays, and any test results (Protected Health Information) to:

INFINITY DENTAL ARTS
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PERIO-CHARTING **PERIODONTAL HISTORY** **IMPLANT HISTORY**

Signature _____ Date _____

Witness _____ Date _____