Oreskovich
DENTAL · CLINIC

DENTAL RECORDS RELEASE FORM

Name_____Date of Birth_____

I authorize: Oreskovich Dental Clinic
1111 Pueblo Blvd. Way
Suite 140
Pueblo CO 81005
Phone: 719-542-8182
Fax: 719-545-1585

To disclose my records to: _____
Name of Provider

Address:_____

Phone:_____Fax:_____

Email:_____

Signature_____**Date**_____

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