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Patient Records Release Form

Please e-mail the information below to info@drkatiehicks.com

Name of Patient Whose Record is Requested: _____

D.O.B._____

Please provide a copy of the records as indicated below:

__x___ Full health record maintained by this provider

__x___ X-Rays

Date of last FMX/Pano: _____

Date of last Bitewing X-Rays: _____

Signature of Patient: _____

Please e-mail the above information to info@drkatiehicks.com. Thank you.