Authorization of Dental Records Release

Dr. ____

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Please release dental records to:

***Falls* Dental Centre**

John Smallcomb, DMD

Michael Frankman, DDS

5100 S. Cliff Ave.

Sioux Falls, SD 57108

(605)371-9111 Fax (605)334-5902

Email: fallsdental2@gmail.com

Signed: ____

Date: ____

Print each family name with date of birth:

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