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AUTHORIZATION TO RELEASE DENTAL INFORMATION

Please forward all records including X-rays to:

Roger M. Mueller, D.M.D.
3716 Pontoon Road
Granite City, IL 62040

Please send a report of my diagnosis, recommended treatment, and radiographs, as well as other pertinent information concerning my dental needs.

Patient Name _____

Date of Birth_____

Patient Signature _____Date_____