



*peterson dental*  
KURT E. PETERSON D.D.S

**RECORDS RELEASE:**

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Date of Request \_\_\_\_\_

My permission is granted to Dr. \_\_\_\_\_ to disclose to Dr. Kurt Peterson complete information concerning the medical findings and treatment of patient: \_\_\_\_\_. Please include current bitewings, any FMX or PANO taken within the last 5 years, probe readings and dates of 4341, if any. All records can be faxed to the number above or emailed to [insurance@petersondental.com](mailto:insurance@petersondental.com).

Signature \_\_\_\_\_

Address \_\_\_\_\_

Thank You

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