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Authorization to Release Records to Galstan and Ward Family Dentistry

I hereby authorize and agree to hold harmless, Dr. Samuel W. Galstan, Dr. C. Sharone Ward, or any of their staff members, to contact previous providers on my behalf, in order to obtain information and release records to Drs. Galstan and Ward's office.

Print Patients Name:	Date of Request
Provider Records Requested From:	
Records Requested (please check)	
○ Copies of X-Rays	
O Copies of treatment notes	
O Other	