

Alamance Family  
**DENTISTRY**

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**Authorization for the Release of Records**

I, \_\_\_\_\_, request the following information and/or chart copies are  
(Patient / Guardian)

released for: \_\_\_\_\_.  
(Patient's Name)

Patient's Date of Birth: \_\_\_\_\_.

\_\_\_\_\_  
(Patient's / Guardian's Signature)

\_\_\_\_\_  
Date

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**FOR OFFICE USE ONLY**

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\_\_\_\_\_ Completed Letter of Medical Necessity / Prescription for Oral Appliance

\_\_\_\_\_ Clinical Notes regarding examination, findings and diagnoses related to sleep disordered breathing and comorbidities

\_\_\_\_\_ Copy of most recent Sleep Study

\_\_\_\_\_ Completed Dental Clearance Letter

\_\_\_\_\_ Other: \_\_\_\_\_

\*\*\* Please feel free to call our office with any questions \*\*\*