**FAMILY DENTAL CENTER**

**Drs Tinnin, Harris, Johnson, Silvestri PLLC**

**2386 North Green Acres Road**

**Fayetteville, Arkansas 72703**

**479-442-8500**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize the office of:

FAMILY DENTAL CENTER

Drs Tinnin, Harris, Johnson, Silvestri PLLC

2386 North Green Acres Road

Fayetteville, Arkansas 72703

479-442-8500

To release my records, x-rays, etc. by mail or electronic transmission to the office of:

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