Romans & Soltani Dentistry, PLLC
5426 West Genesee Street
Camillus, N.Y. 13031

I, ________________________, am requesting the release of my dental records to be sent to Dr. Romans & Dr. Soltani. X-rays can be emailed to: **INFO@ROMANSSOLTANIDENTISTRY.COM** or mailed to the above address. Thank you in advance for your help with this matter.

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(Patient Name)

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(Signature)

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(Date)