



Morris Dental Care

170 Changebridge Road. Suite D5-2
Montville NJ, 07045
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Date: _____

I give permission to release my/family dental records/X-Ray(s) to:

_____ 170 Changebridge Rd. Suite D5-2
Montville NJ, 07045

_____ Other

Patient name: _____

Patient/Guardian Signature: _____