Kent Lane Mueller, D.D.S.

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PATIENT RECORDS ACCESS REQUEST FORM

I hereby request a copy of my medical record as detailed below:

[] Full medical and dental record held by this office
[] All pertinent X-Rays (FMX or PAN if less than 5 years)
[] A specific portion/section of the record as follows:

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Please forward all records to Kent Lane Mueller, D.D.S. at the above address.

Patient Name:	
Signature:	Date: