ASPIRE
IMPLANT DENTISTRY CENTER

RECORDS/INSURANCE RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payees and/or health practitioners.

SIGNATURE: _____ ***DATE:*** _____

I understand that Aspire the Denture Solution does not participate in my dental insurance plan and that I am responsible for all costs of dental treatment rendered.

SIGNATURE: _____ ***DATE:*** _____

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