



Heather T. Hudkins, DDS, PC
General Dentist

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Pediatric Dentist

RELEASE OF RECORDS

I, _____, give my permission for Dr. Heather Hudkins or Dr. William Brell to release my child or children's record to _____ at this address:

Child's or Children's Name _____

Signature of Parent or Legal Guardian _____

Date: _____

dentistry for children

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